

**BALANCE AND VESTIBULAR SERVICES AT LEE MEMORIAL HEALTH SYSTEM**

*We would like to welcome you to our facility. In order to make your initial visit efficient we are asking that you take the time to fill out the following paperwork as thoroughly as possible. We look forward to seeing you!*

**Referring Physician:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

**Care from other Physicians / Healthcare Providers:** \_\_\_\_\_

*If you would like a copy of your report to be sent to another physician besides your referring physician, please sign here:* \_\_\_\_\_

*Provide Physician Name:* \_\_\_\_\_ *Fax Number:* \_\_\_\_\_

**Primary Contact Person:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

**Chief Complaint / Symptoms:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Loss of Balance while Standing Still           | <input type="checkbox"/> Vertigo/Spinning         | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Difficulty reading               |
| <input type="checkbox"/> Loss of Balance with Walking                   | <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Giddiness               | <input type="checkbox"/> Difficulty focusing eyes         |
| <input type="checkbox"/> Veering during Walking                         | <input type="checkbox"/> Near fainting            | <input type="checkbox"/> Confusion               | <input type="checkbox"/> Difficulty with computer screens |
| <input type="checkbox"/> Unsure on feet                                 | <input type="checkbox"/> Black Out                | <input type="checkbox"/> Difficulty word finding | <input type="checkbox"/> Blurry Vision                    |
| <input type="checkbox"/> Falling  | <input type="checkbox"/> Vomiting                 | <input type="checkbox"/> Tingling                | <input type="checkbox"/> Double Vision                    |
| <input type="checkbox"/> Near Falls                                     | <input type="checkbox"/> Floating in head         | <input type="checkbox"/> Numbness                | <input type="checkbox"/> Motion Sickness                  |
| <input type="checkbox"/> Fear of Falling indoors 0-10: ____/10 (worst)  | <input type="checkbox"/> Pressure in head         | <input type="checkbox"/> Pain                    | <input type="checkbox"/> Other(s): _____                  |
| <input type="checkbox"/> Fear of Falling outdoors 0-10: ____/10 (worst) | <input type="checkbox"/> Migraines                | <input type="checkbox"/> Clumsiness              | _____   |
| <input type="checkbox"/> Dizziness                                      | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Problems with neck      | _____   |
| <input type="checkbox"/> Lightheadedness                                | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Neck pain               | _____   |

**Symptoms:** Present since: \_\_\_\_\_  Worsening  Improving  No Change

**Onset:**  Gradual  Sudden  No Known Cause  Specific Incident: \_\_\_\_\_

Most Recent Attack: \_\_\_\_\_

**Symptoms:**  Constant  Intermittent - Lasting:  Seconds: \_\_\_\_\_  Minutes: \_\_\_\_\_  Hours: \_\_\_\_\_  Days: \_\_\_\_\_

Any previous treatments for present condition? . . . . .  No  Yes: \_\_\_\_\_

Any recent hospitalization? . . . . .  No  Yes: \_\_\_\_\_

**Precipitating Factors / Symptoms Brought on by:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Standing up from sitting   | <input type="checkbox"/> Being in a crowd | <input type="checkbox"/> Stress                                     | <input type="checkbox"/> Rolling in bed             |
| <input type="checkbox"/> Eye movements              | <input type="checkbox"/> Reading          | <input type="checkbox"/> Prolonged sitting                          | <input type="checkbox"/> Getting up to sit from bed |
| <input type="checkbox"/> Movement of surroundings   | <input type="checkbox"/> Using computer   | <input type="checkbox"/> Coughing/Sneezing                          | <input type="checkbox"/> Looking up                 |
| <input type="checkbox"/> Riding in an elevator      | <input type="checkbox"/> Watching TV      | <input type="checkbox"/> Blood Sugar increase / decrease            | <input type="checkbox"/> Bending over               |
| <input type="checkbox"/> Riding Up / Down escalator | <input type="checkbox"/> Lights           | <input type="checkbox"/> Blood Pressure Changes increase / decrease | <input type="checkbox"/> Turning Quickly            |
| <input type="checkbox"/> Quick head movements       | <input type="checkbox"/> Noise            | <input type="checkbox"/> Poor Eating Habits                         | <input type="checkbox"/> Being in the dark          |
| <input type="checkbox"/> Walking on uneven surfaces | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Hunger                                     | <input type="checkbox"/> Other(s): _____            |
| <input type="checkbox"/> Riding in a car            | <input type="checkbox"/> Insomnia         | <input type="checkbox"/> Alcohol                                    | _____   |
| <input type="checkbox"/> Being in Grocery Store     | <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Menstrual Cycle                            | _____   |
| <input type="checkbox"/> Being in Shopping Mall     | <input type="checkbox"/> Exertion         | <input type="checkbox"/> Lying down in bed                          | _____   |

**What Makes Symptoms Better?**

- |  |                                       |                                   |  |
|--|---------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Staying Still | <input type="checkbox"/> Sitting      | <input type="checkbox"/> Activity | <input type="checkbox"/> Relaxation Techniques |
| <input type="checkbox"/> Lying Down    | <input type="checkbox"/> Closing Eyes | <input type="checkbox"/> Alcohol  | <input type="checkbox"/> Nothing               |
| <input type="checkbox"/> Sleeping      | <input type="checkbox"/> Medication   | <input type="checkbox"/> Eating   | <input type="checkbox"/> Other: _____          |

**LEE MEMORIAL HEALTH SYSTEM**  
Lee County, Florida  
**HEALTH HISTORY CARE LOG ADDENDUM**  
**FOR BALANCE/VESTIBULAR**

**BALANCE SPECIFIC HEALTH HISTORY**

- CARDIAC:**                     Atrial Fibrillation                     Orthostatic Hypotension
- RESPIRATORY:**            Sleep Apnea
- NEUROLOGICAL:**         Acoustic neurome                     Fainting Episodes                     Migraines
- Numbness in Face                     Weakness/Paralysis in Face            Whiplash
- PSYCHOLOGICAL:**        Anxiety                                     Psych Hospitalization                     Substance Abuse
- INFECTIOUS DISEASE:**  Nightsweats                             Prolonged IV/Antibiotic Treatment
- GASTROINTESTINAL:**  Reflux Disease                            Weight Loss/Gain
- CANCER:**                     Chemotherapy                            Radiation
- ENT:**                             Ear Surgery                                 Ear Trauma                                 Meniere's
- Motion Sickness
- MISCELLANEOUS:**        Rheumatoid Arthritis                     Do you drink alcohol?                     Do you snore?

**MEDICATIONS RELATED TO MANAGEMENT OF VERTIGO/BALANCE SYMPTOMS**

- Antivert (Meclizine). . . . .  No  Yes: \_\_\_\_\_
- Bonine . . . . .  No  Yes: \_\_\_\_\_
- Dramamine. . . . .  No  Yes: \_\_\_\_\_
- Scopolomine . . . . .  No  Yes: \_\_\_\_\_
- Valium . . . . .  No  Yes: \_\_\_\_\_
- Other: \_\_\_\_\_

- Vision**    Last Vision Test: \_\_\_\_\_    Last Eye Glass Prescription Change: \_\_\_\_\_
- Glasses:  Reading  Distance  Progressive  Prism  Bifocals  Trifocals  Contacts  Implants
- Blindspots  Blindness: . . .  Left  Right  Both \_\_\_\_\_
- Diabetic Retinopathy: . . . . .  Left  Right  Both \_\_\_\_\_
- Macular Degeneration: . . . . .  Left  Right  Both \_\_\_\_\_
- Cataracts: . . . . .  Left  Right  Both \_\_\_\_\_
- Blurred Vision: . . . . .  Left  Right  Both \_\_\_\_\_
- Glaucoma: . . . . .  Left  Right  Both \_\_\_\_\_
- Double Vision: . . . . .  Horizontal  Vertical  Constant  Intermittent

- Hearing**    Last Hearing Test: \_\_\_\_\_    Any Hearing Aids:  Right  Left  Both
- Hearing Loss . . . . .  R  L; If yes:  Sudden  Gradual
- Ear Pain . . . . .  Left  Right  Both \_\_\_\_\_
- Ear Pressure . . . . .  Left  Right  Both \_\_\_\_\_
- Ear Fullness . . . . .  Left  Right  Both \_\_\_\_\_
- Ear Discharge . . . . .  Left  Right  Both \_\_\_\_\_
- Ear Wax. . . . .  Left  Right  Both \_\_\_\_\_
- Tinnitus (ringing in the ears) .  Left  Right  Both \_\_\_\_\_
- Ear Infection . . . . .  Left  Right  Both \_\_\_\_\_

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**RECENT MEDICAL TESTS**

IF BOX IS CHECKED, PLEASE INDICATED DATE OF LAST TEST ON THE LINE PROVIDED.

- MRI . . . . . \_\_\_\_\_
- Doppler (carotid or legs) . . . . . \_\_\_\_\_
- Blood Tests . . . . . \_\_\_\_\_
- CT Scan. . . . . \_\_\_\_\_
- Magnetic Resonance Angiography (MRA) . . . . . \_\_\_\_\_
- ENG/VNG . . . . . \_\_\_\_\_
- EMG . . . . . \_\_\_\_\_
- Nerve Conduction Studies . . . . . \_\_\_\_\_
- X Ray . . . . . \_\_\_\_\_

**Have you had any falls in the last year?**  Yes, how many in the past 12 months? \_\_\_\_\_  No

Date of Last Fall? \_\_\_\_\_ Any major injuries? \_\_\_\_\_ Did you seek medical assistance?  Yes  No

I have had near falls:  Daily  Weekly  Monthly  No falls or near falls

**HOME ENVIRONMENT**

**Full-Time Florida Resident:**  Yes  No, only in FL # \_\_\_\_\_ months  
 What other state? \_\_\_\_\_ Leaving FL: \_\_\_\_\_

**Dwelling:**  House  Condo/Apartment  Mobile Home/Trailer  Boat  Other: \_\_\_\_\_

**Steps:**  To Enter Home  Within Home  Number \_\_\_\_\_ Rails:  Right  Left  None

**Home Adaptive Equipment:**  Ramp  Grab Bars in shower / by toilet / other: \_\_\_\_\_  
 Raised Toilet Seat  Urinal  Shower Seat  Hospital Bed  
 Automatic Bed  Lift Chair  Night Lights  Lifeline  
 Other: \_\_\_\_\_

**Equipment:** That you have and use: \_\_\_\_\_  
 Available equipment at home that you do not use: \_\_\_\_\_

**COMMUNITY SERVICES YOU USE:**  
 Food Services  Cleaning  Transportation  Activities of daily living, such as grooming, bathing, dressing, etc.  
 Other: \_\_\_\_\_

**Present Level of Activity/Hobbies:** \_\_\_\_\_

**Any activities you have stopped doing because of your problem?** \_\_\_\_\_

**Are you Driving:**  Yes  No; check reason:  No Reason  No License  Medication  Illness  Fear  
 Doctor Orders  Family Request  Other: \_\_\_\_\_

Do you have a handicapped sticker? . . . . .  Yes  No

*I have reviewed this form and will update the information as changes occur.*

**THERAPIST SIGNATURE:** \_\_\_\_\_ **DATE/TIME:** \_\_\_\_\_ **LICENSE #:** \_\_\_\_\_

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