StopFalls CANADA
Balance and Dizziness Clinic

www.stopfallsclinic.ca

1100 Sheppard Ave, East, Suite 102
North York, ON, M2K 2W1
Tel: 647 345 2444 Fax: 645 345 2445
stopfallsclinic@gmail.com

Vestibular Case History

Name: ______________________________ **Health Card #**________________________ **Date:** ________________

Date of Birth:_________________________ **Gender: M / F**

1. **Describe your symptoms without using the word 'dizzy':**
   ____
   ____
   ____
2. **When did the symptoms begin? What do you do when you feel the symptoms?**
   ____
   ____
   ____
3. **How long do your symptoms last?**
   ____
4. **Have you had these symptoms before?** ☐ **Yes** ☐ **No**
5. **How often do you experience these symptoms?**
   ____
6. **Are these** ☐ **Single or** ☐ **Multiple attacks?**
7. **When the symptoms occur are objects:** ☐ **spinning around you or** ☐ **are you spinning around objects?**
8. **Is there anything that you do to make the symptoms stop?** ________________________________
   ____
   ____
9. **Is there anything that causes the symptoms to become worse?**
   ____
   ____
10. **Are you currently taking medications?** ☐ **Yes** ☐ **No**
    If Yes please list:
    ____
    ____
    ____
11. **Do you use:** ☐ **Recreational Drugs** ☐ **Alcohol** ☐ **Caffeine (coffee/tea etc.)**

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12. Do you or any immediate members of your family have any of the following diseases or conditions?

☐ Meniere's Disease ☐ Stroke ☐ Heart Disease
☐ Hearing Loss ☐ Headache/Migraine ☐ Anxiety/Depression
☐ Sinus Problems ☐ Neurological Disorder ☐ Diabetes
☐ Other: ____

13. Do you have any of the following symptoms?

Difficulty Hearing? ☐ Both Ears ☐ Right Ear ☐ Left Ear

Does Hearing Change with the symptoms? How? ____

____

Noise in Your Ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

Does the Noise change with the symptoms? How? ______________________________________

____

Fullness, pressure, or stuffiness in your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

Does this sensation change with the symptoms? How?

____

____

14. Do you currently have any eye disorder(s)? Please list:____
____
____

15. Do the symptoms have a positional trigger?
____

16. Have you had any tests or treatment related to your symptoms by any other medical professionals and if you so what were the results?

☐ Hearing tests ☐ Balance Function Tests ☐ Physical Therapy
☐ Blood tests ☐ Cardiovascular tests ☐ MRI ☐ CT

Results: ____

17. Is there anything else you would like to make sure the doctor knows about, or is there anything you would like to add?
____
____