Physical Therapy & Vestibular Rehabilitation

Blood Pressure

Dizzy Medical History

Name: _____ Age: _____ Date: _____

Height:_____ft____in__ **Weight:**_____lbs_

Please complete this form to the best of your ability. If you have any questions, please ask the receptionist.
Have you ever experienced any of the following *(mark in column Y for yes, N for no)*?

	Y	N		Y	N		Y	N
Bladder Difficulties			Headaches			Osteoporosis/Osteopenia		
Bowel Difficulties			Migraine			Recent Fever		
Depression/Anxiety			Hypertension			Seizures		
Diabetes			Lung Disease			Smoker		
Dizziness			Obesity			Taking Steroids		
Sinus Issues			Heart Disease			Joint Surgeries		
Fullness in Ears			Cancer			**COVID Vaccine**		
Noise in Ears			Circulatory Disorder			**Positive COVID test**		
Double Vision			***Circle***:Upper / Lower Extremities			When: _____		

Eye health/surgeries_____ *circle any that apply*: glaucoma macular degeneration cataracts

Allergies: _____

Past medical history: _____

_____

_____

_____

_____

Previous dizziness episodes:_____

_____

_____

Previous therapy:_____

_____

_____

_____

Diagnostic tests: VNG Computerized Posturography Hearing VEMP

MRI: Date: _____Body Part: _____Location: _____

Rate your Dizziness on a scale of 0 to 10 (0 if no symptoms, 10 is enough to severely interfere with function)

at rest 0_____10

with activity 0_____10

Rate your Disequilibrium while:

Standing 0_____10

Walking 0_____10

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List all prescriptions, over-the-counters, herbals, vitamins and dietary supplements:

Name	Dosage	Frequency	Administration (oral, spray, injectable, etc.)