



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	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	Taking Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Issues	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Fullness in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	COVID Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Noise in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Positive COVID test	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<i>Circle:</i> 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

