**\*Please carefully read and follow instructions listed below PRIOR to your vestibular evaluation appointment:**

**Before your appointment:**

* Stop taking any medication used to treat dizziness or nausea **48 hours prior** to your appointment.
* Do not consume alcohol **12 hours prior** to your appointment.
* Do not eat anything **8 hours prior** to your appointment.
* Do not drink any fluids **1 hour prior** to your appointment.
* Be sure your **EYES** **FACE** and **NECK** are free of any lotion or makeup products.
* Be sure your neck is free of any **FACIAL HAIR.**
* Complete this intake form prior to your appointment.

**For your appointment:**

* Bring a list of all medications including frequency of use and dosage.
* Wear comfortable clothing.
* Mild dizziness can be expected throughout the testing. Your Vestibular Specialist will make testing as comfortable as possible.

**\*Please complete the following intake form PRIOR to your appointment:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Approximately when did your symptoms begin and how long have they been occurring for?

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**WITHOUT** using the words “dizzy” or “vertigo” describe what your symptoms feel like in detail:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE ANSWER (**Y**=YES and **N**=NO) THAT MOST PERTAINS TO YOU. IF A LINE IS PROVIDED, PLEASE ANSWER APPROPRIATELY.

How often does your dizziness/vertigo occur? DAILY/WEEKLY/MONTHLY

How long does the dizziness/vertigo last when it comes on? SECONDS/MINUTES/HOURS/DAYS

Does your dizziness/vertigo occur when lying down for bed or getting up in the morning? Y/N

Do you have a history of headaches or migraines? Y/N

* How often are the headaches occurring? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How long do the headaches last for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a sensitivity to bright lights? Y/N

Do you have a sensitivity to loud sounds? Y/N

Do you have any numbness or tingling in your face at anytime? Y/N

Do you experience visual auras? (Ie. Tunnel Vision, Colored Spots, etc.) Y/N

Do you experience motion sickness or a sensitivity to motion? (ie. Riding in the car) Y/N

Have you had any surgeries anywhere on your head or neck? Y/N

Do you have a history of cancer? Y/N

Do you have a history of high blood pressure? Y/N

Do you have a history of diabetes? Y/N

Do you have any autoimmune disorders? Y/N

Do you have neuropathy in your toes or feet? Y/N

Does your dizziness/vertigo fluctuate in intensity? Y/N

Do you have hearing loss? Y/N If **YES**: RIGHT EAR/LEFT EAR/BOTH EARS

Do you have tinnitus (ear ringing or roaring)? Y/N If **YES**: RIGHT EAR/LEFT EAR/BOTH EARS

Do you have ear pressure/fullness? Y/N If **YES**: RIGHT EAR/LEFT EAR/BOTH EARS

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

Do you have a room spinning sensation when exposed to **extremely** loud sounds? Y/N

Did your dizziness begin after being on a boat/cruise ship for an extended period? Y/N

Does your dizziness feel better when you are moving but worse when you are sitting still? Y/N

Have you ever fallen? Y/N

If **YES** how many times have you fallen in the last year? \_\_\_\_\_\_\_\_\_\_\_\_

If **YES** was it due to your dizziness? Y/N

Have you ever had head trauma? Y/N

If **YES** did this result in a diagnosed concussion? Y/N

Approximately when was the last time you had head trauma? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of **moderate to severe** neck or back pain? NECK/BACK/BOTH

Do you have a history of substance abuse? Y/N

Do you use marijuana? Y/N

Do you use alcohol? Y/N

Do you use any tobacco products? Y/N

Do you have history of anxiety or depression? Y/N

If **YES** is your condition being treated by therapy or medication?

NONE/THERAPY/MEDICATION/BOTH

MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_