Business Name
Address 1
Address 2
City, State, Zip
Phone
Fax

Patient Name: _____ **Date of Birth:** _____

Provider Name: _____ **Today's Date:** _____

Sex: _____

Since they have begun, have your symptoms, Stayed the Same

If they have changed or improved, please provide more details.

_____

_____

Section does not apply ☐ **Last episode:** _____

How long do your symptoms last without stopping? Seconds

Which of the following can provoke your dizziness?

Hold down Ctrl to select multiple items

- Bending Over
- Increased stress
- Laying Down
- Looking Up
- Not drinking enough water
- Rolling over in bed
- Skipping a meal
- Standing from seated position
- Standing up from bending over
- Turning your head right or left while sitting or standing

How often do you have an episode?

times a month

Any other triggers? _____

_____

Section does not apply ☐

Are you veering/leaning while walking? No

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Have you fallen in the past year:

How many times? #

Inside the home? No

Outside the home? No

Have you experienced "Near Falls" but caught yourself? No

Have you started any new medications prior to your imbalance? No

Have you had any new diagnoses or procedures occur around the onset of your imbalance? No

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