ACI HEARING & BALANCE CENTER

103 Saint Thomas Street
Lafayette, Louisiana 70506
(337) 235-6601

PLEASE COMPLETE THIS HISTORY FORM **PRIOR** TO YOUR APPOINTMENT & BRING WITH YOU ON THE DAY OF EXAM

~ THANK YOU

Case History and Subjective Test Measures

Name:_____ **Date:**_____

What has been done for your dizziness/imbalance thus far? (Doctors/Medication/Clinics & Dates)

_____

_____

If you've been prescribed medication, when was the last time you took it?

MEDICAL HISTORY:

- ☐ Circulatory/Vascular
- ☐ Diabetes
- ☐ Numbness of face, hands, or feet?
- ☐ Stroke/Neurological condition
- ☐ Seizures/Convulsions
- ☐ Loss of consciousness
- ☐ Trauma or Blow to the head
- ☐ Life threatening infection
- ☐ Cancer
- ☐ Cardiac/Heart disease
- ☐ High ☐ Low Blood Pressure
- ☐ Pain in shoulders or neck
- ☐ Tendency to fall
- ☐ Orthopedic conditions:

  _____
- ☐ Flu/Virus: (please specify)

  _____
- ☐ Cancer

  _____
- ☐ Other

  _____
- ☐ Ear Infections or surgery (please specify):
  ☐ recent ☐ past ☐ childhood
- ☐ Headaches (please specify):
  ☐ recent ☐ past ☐ migraines
- ☐ Sinus problems or Asthma
- ☐ Vision:
  - ☐ Glaucoma
  - ☐ Blurred vision or blindness
  - ☐ Double vision
  - ☐ New glasses recently
  - ☐ Cataracts – R ☐ Cataracts – L
  - ☐ Other: _____

  Corrected with:
  - ☐ Surgery ☐ lenses
- ☐ Dizziness/Vertigo
  - ☐ recent ☐ past
  - ☐ motion sickness ☐ family
- ☐ Surgeries (please specify):

  _____

  _____

  _____
- ☐ MRSA ☐ VRE
- ☐ Exposure to irritating fumes, paints, etc.
- ☐ Difficulty swallowing or tingling around the mouth
- ☐ Odd or strange tastes in your mouth
- ☐ Allergies? To what _____
- ☐ Dizziness assc. with menstrual period recent hormonal changes

HEARING

Have you had any recent changes in your ears?

Difficulty hearing?	☐ Right	☐ Left	☐ Both
Distortion in hearing?	☐ Right	☐ Left	☐ Both
Noises in the ear?	☐ Right	☐ Left	☐ Both
Does this change when you are dizzy?		YES	NO
Pressure/pain in your ears?	☐ Right	☐ Left	☐ Both
Does this change when you are dizzy?		YES	NO
Drainage from your ears?	☐ Right	☐ Left	☐ Both
Noise in your ears?	☐ Right	☐ Left	☐ Both
Sensitivity to loud noise?	☐ Right	☐ Left	☐ Both

Describe:_____

MEDICATIONS:

Please list current medications (including over the counter drugs or herbal supplements):

_____

_____

Please list any medications you have tried in the past for balance problems:

_____

Have you taken any of the above medications within the past 36 hours? YES NO If yes, which ones?

PERSONAL HABITS:

Average hours of sleep each night? _____
Caffeine intake (coffee, tea, soda) _____ cups/ glasses per day
Alcohol intake _____ drinks per day
Recreational or illicit drug use _____
Tobacco use _____ pack(s) per day
Aerobic exercise _____ times per week
Exposure to loud noises? _____
Exposure to toxic substances? _____

SYMPTOMS:

When did you first notice a problem with your imbalance/dizziness?

_____

Please describe your original onset of imbalance/dizziness.

☐ lightheaded ☐ swimmy ☐ disoriented ☐ spinning ☐ tumbling
☐ rocking ☐ tilted ☐ giddy ☐ other _____

Has this changed since the problem began? If so, how would you describe it now?

_____

Prior to experiencing these symptoms, what was your level of function?

☐ Independent with all activities
☐ Needed minimal assistance with activities of daily living
☐ Needed moderate assistance to perform activities of daily living
☐ Needed total assistance to perform activities of daily living

Rate your current symptoms (1 = no symptoms, 10 = severe symptoms):

Dizziness (DAS):

No symptoms [☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10] Severe symptoms

Imbalance (DyAS):

No symptoms [☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10] Severe symptoms

Are your symptoms: ☐ Constant ☐ Occurring in attacks ☐ With warning
☐ Comes and goes ☐ Without warning

If you have dizziness/imbalance in between your attacks, describe: _____
When was your last attack/episode? _____
How often do the attacks occur? _____
How long do they last? ☐ < 1 minute ☐ >1 minute ☐ Hours ☐ Days
What makes your symptoms better? _____

What makes your symptoms worse? _____

Please describe your problem/symptoms

_____

_____

_____

_____

Have you had difficulty speaking? ☐ Yes ☐ No
Have you had numbness of the hands, feet, mouth, or face? ☐ Yes ☐ No

HEADACHE

Do you have frequent headaches? _____
Are your headaches associated with nausea/vomiting?_____
How often do you take medication for headaches? (daily/_____ per week/_____ per month/ _____)
How long do your headaches last? _____
When did you first start getting headaches? _____
Have you been diagnosed with migraine headaches? _____

PREVIOUS TESTING

Audiogram (hearing test)?	☐ Yes	☐ No	☐ Normal	☐ Abnormal
CT Scan?	☐ Yes	☐ No	☐ Normal	☐ Abnormal
MRI?	☐ Yes	☐ No	☐ Normal	☐ Abnormal

SOCIAL HISTORY:

Occupation: _____

Job responsibilities: _____

With whom do you live? ☐ Alone ☐ Spouse ☐ Other _____
If you live alone, do you have assistance from anyone? ☐ Yes ☐ No

You require assistance for what activities: _____
Do you use a: ☐ walker ☐ cane ☐ wheelchair

DIZZINESS HANDICAP INVENTORY (DHI)

Please **Check** the correct response:

1. I have dizziness/unsteadiness: ☐ 1 per month ☐ > 1 but < 4 per month ☐ more than 1 per week
2. My dizziness/unsteadiness is: ☐ mild ☐ moderate ☐ severe

Instructions: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "YES", "SOMETIMES", or "NO" to each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

Does looking up increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does bending over increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does turning over in bed increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does walking down the aisle of a supermarket increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Do quick movements of your head increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does going down a sidewalk increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Do you have trouble getting into/out of bed	☐ Yes	☐ Sometimes	☐ No	F
Do you have difficulty reading?	☐ Yes	☐ Sometimes	☐ No	F
Because of your problem is it difficult for you to do strenuous house work or yard work?	☐ Yes	☐ Sometimes	☐ No	F
Is it difficult for you to walk around the house in the dark?	☐ Yes	☐ Sometimes	☐ No	F
Interfere with your household responsibilities or job?	☐ Yes	☐ Sometimes	☐ No	F
Do you avoid heights?	☐ Yes	☐ Sometimes	☐ No	F
Does your problem significantly restrict your participation in social activities such as going out to dinner, going to a movie, dancing, or to parties?	☐ Yes	☐ Sometimes	☐ No	F
Do you restrict your travel for business or recreation?	☐ Yes	☐ Sometimes	☐ No	F
Is it difficulty for you to walk by yourself?	☐ Yes	☐ Sometimes	☐ No	F
Do you feel handicapped?	☐ Yes	☐ Sometimes	☐ No	F
Are you afraid to leave your home without someone to accompany you?	☐ Yes	☐ Sometimes	☐ No	F
Are you embarrassed in front of others?	☐ Yes	☐ Sometimes	☐ No	F
Because of your problem, is it difficult for you to concentrate?	☐ Yes	☐ Sometimes	☐ No	E
Because of your problem, Do you feel frustrated?	☐ Yes	☐ Sometimes	☐ No	E
Are you afraid people may think you are intoxicated?	☐ Yes	☐ Sometimes	☐ No	E
Are you afraid to stay home alone?	☐ Yes	☐ Sometimes	☐ No	E
Are you depressed?	☐ Yes	☐ Sometimes	☐ No	E
Place stress on your relationships with family or friends?	☐ Yes	☐ Sometimes	☐ No	E

For office use only: _____ x4 _____ x2 _____ x0

Total: _____

	Yes	Sometimes	No	Total
P	4 x	2 x	0 x	
F	4 x	2 x	0 x	
E	4 x	2 x	0 x	

100-70 = Severe perception of handicap; 69-40 = Moderate perception of handicap; 39–0 = Low perception of handicap

>60 = Increased fall risk