OHSUHealth
Hillsboro Medical Center

VESTIBULAR QUESTIONNAIRE

Date: _____

Please rate your dizziness over the last few days on a scale of 0-10.
0 = no dizziness 10= worst dizziness imaginable. You may indicate a range, for example: 0-3/10

_____ /10

How many days per week are you experiencing your symptoms? _____

Are you experiencing any of the following symptoms?

- ☐ dizziness
- ☐ loss of balance
- ☐ fogginess
- ☐ memory problems
- ☐ nausea
- ☐ light headedness
- ☐ fullness or pressure in the ears
- ☐ ringing in the ears
- ☐ sensitivity to noise
- ☐ sensitivity to light

Do you feel the sense of spinning or that the room is spinning around you? ☐ Yes ☐ No

How long does the spinning last? _____

When was the last time it occurred? _____

Do you have symptoms with rolling in bed? ☐ Yes ☐ No

Do you have symptoms with getting out of bed? ☐ Yes ☐ No

Do your symptoms increase with any of the following activities?

- ☐ Fatigue
- ☐ Busy Environments
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Riding in a car
- ☐ Reading
- ☐ Computer/phone use

Are you taking any medications for your dizziness? _____

Do you have any history of the following diagnoses?

- ☐ Neck pain or surgery
- ☐ Migraines
- ☐ Meniere's Disease
- ☐ Concussion
- ☐ Stroke

Have you fallen in the past month? _____ If yes, how many times?_____
How did it happen? _____

(Please complete other side →)

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DIZZINESS HANDICAP INVENTORY

Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes," "No," or "Sometimes" to each question. ***Answer each question as it pertains to your dizziness or unsteadiness problem only. Please circle one.***

Y	S	N	P1. Does looking up increase your problem?
Y	S	N	E2. Because of your problem, do you feel frustrated?
Y	S	N	F3. Because of your problem, do you restrict your travel for business or recreation?
Y	S	N	P4. Does walking down an aisle of a supermarket increase your problem?
Y	S	N	F5. Because of your problem, do you have difficulty getting into or out of bed?
Y	S	N	F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or going to parties?
Y	S	N	F7. Because of your problem, do you have difficulty reading?
Y	S	N	P8. Does performing more ambitious activities, like sports, dancing, household chores such as sweeping or putting dishes away, increase your problem?
Y	S	N	E9. Because of your problem are you afraid to leave your home without having someone accompany you?
Y	S	N	E10. Because of your problem, have you been embarrassed in front of others?
Y	S	N	P11. Do quick movements of your head increase your problems?
Y	S	N	F12. Because of your problem, do you avoid heights?
Y	S	N	P13. Does turning over in bed increase your problem?
Y	S	N	F14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?
Y	S	N	E15. Because of your problem, are you afraid people may think you are intoxicated?
Y	S	N	F16. Because of your problem, is it difficult for you to go for a walk by yourself?
Y	S	N	P17. Does walking down a sidewalk increase your problem?
Y	S	N	E18. Because of your problem, is it difficult for you to concentrate?
Y	S	N	F19. Because of your problem, is it difficult for you to walk around your house in the dark?
Y	S	N	E20. Because of your problem, are you afraid to stay at home alone?
Y	S	N	E21. Because of your problem, do you feel handicapped?
Y	S	N	E22. Has your problem placed stress on your relationships with members of your family or friends?
Y	S	N	E23. Because of your problem, are you depressed?
Y	S	N	F24. Does your problem interfere with your job or household responsibilities?
Y	S	N	P25. Does bending over increase your problem?

(Please complete other side →)

Welcome! Please fill this out to the best of your ability and return to the front desk. Thank you!

Date: _____ Date of Injury/Start of symptoms:_____

Reason for visit (pain, balance etc): _____

Height: _____ Weight: _____

Occupation: _____

Pronoun: (please circle) HE/HIS SHE/HER THEY/THEM

Activity	**CURRENT** Rating										
We want to know **your goals** to help us guide your care. Please list important activities that you are unable to do or are having difficulty with. ***WHAT ACTIVITIES DO YOU HAVE DIFFICULTY WITH BECAUSE OF YOUR PROBLEM?***	0 = **Unable** to perform activity										10 = **Able** to perform activity at same level as before injury or problem
List up to 3 activities below.	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1.											
2.											
3.											

Currently I am experiencing (check all that apply):

- ❑Fever/chills/sweats
- ❑Numbness or Tingling
- ❑Depression
- ❑Headaches
- ❑Fatigue
- ❑Changes in bowel or bladder function
- ❑Poor balance (falls)
- ❑Changes in appetite
- ❑Shortness of breath
- ❑Nausea /Vomiting
- ❑Difficulty sleeping
- ❑Unexplained weight loss
- ❑Difficulty swallowing
- ❑Dizziness
- ❑Increased pain at night
- ❑Difficulty concentrating, thinking

Please Circle any medical or surgical history we should be aware of:

- ❑Arthritis
- ❑Blood Clots
- ❑Blood disease
- ❑Cancer
- ❑Diabetes
- ❑Drug-resistant infection
- ❑Epilepsy/Seizures
- ❑Fiborymylagia
- ❑Heart Condition
- ❑Hernia
- ❑High Blood Pressure
- ❑High Cholesterol
- ❑Kidney Disease/ Dialysis
- ❑Liver Disease/ Hepatitis
- ❑Lymphedema
- ❑Multiple Sclerosis
- ❑Spinal cord injury
- ❑Stroke/TIA
- ❑Thyroid disorder
- ❑Vision Problems
- ❑Memory Problems
- ❑Other: _____
- ❑Are you pregnant/ nursing?

Do you smoke? ❑Yes ❑No

Are you allergic to latex and/or adhesives? Yes/ No

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Falls

Are you worried about falling or losing your balance? _____

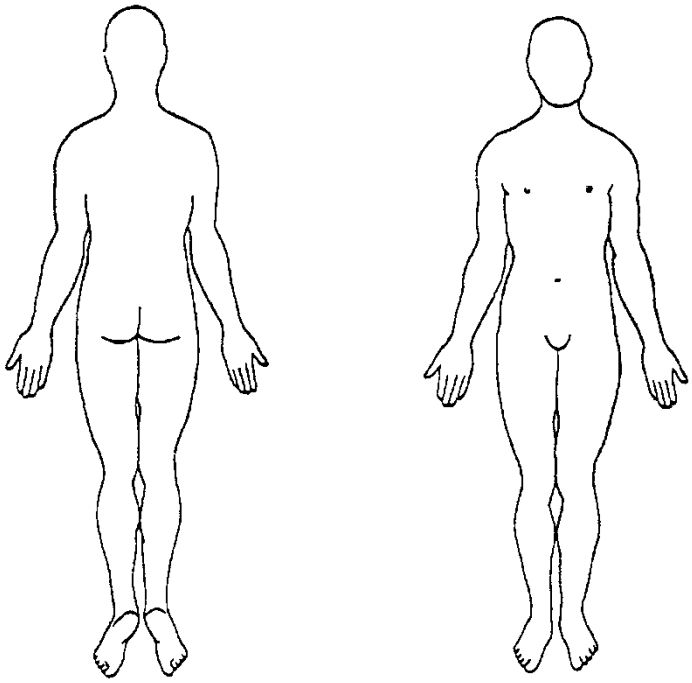
How many **falls or near-falls** have you had in the past 6 months? _____

Body Chart:

On the body diagrams to the right, please mark the areas where you have symptoms:

(Left) – **Back** – (Right)

(Right) –**Front** – (Left)



Circle any that apply:

Shooting/sharp pain
Dull/aching pain
Numbness
Tingling

My symptoms currently:

❑ Come and go
❑ Are constant
❑ Are constant, but change with activity

My symptoms are worse with:_____

My symptoms are better with: _____

Please rate your pain 0-10/10 over the last couple days/weeks. 0=no pain, 10=worst pain imaginable.

Pain currently: _____
Pain at lowest: _____
Pain at highest: _____

What do you do in your free time/what are your hobbies? _____
_____

Is there anything else you would like for us to be aware of?_____
_____