NORTHERN ILLINOIS UNIVERSITY
Clinical Services
College of Health and Human Sciences

NIU Speech-Language-Hearing Clinic
3100 Sycamore Road
DeKalb, IL 60115
815-753-1481 (PHONE) 815-753-1664 (FAX)

Legal Name_____ Today's Date_____

Preferred Name_____ Date of Birth _____ Age_____

Address_____ City_____ State_____ ZIP_____

Sex_____ Gender Identity_____ Preferred Pronouns_____

Phone Number_____ Email_____

Do you prefer to be contacted by phone or email?_____

Primary Care Physician_____

Ear, Nose, & Throat Physician (if any)_____

PRESENT CONCERNS

Who referred you to this clinic?_____

Briefly describe your issue or concerns._____

_____

_____

_____

When did your issue start?_____

Was the onset of your dizziness sudden or gradual? _____

Is your dizziness constant/intermittent? _____

How long does the dizziness last? _____

How often does it occur? When does it occur? _____

_____

When did dizziness/imbalance start? Was there any related event? _____

_____

When walking do you veer right, left, or remain on straight path? _____

Do you have any of these symptoms/conditions (mark all that apply):

	Lightheaded		Nausea or vomiting		Double vision
	Fainting or nearly fainting		Weakness		Blurry vision
	Feeling like I'm spinning		Difficulty swallowing		Headaches
	Feeling like the world is spinning		Difficulty speaking		Loss of vision
	Clumsy or unsteady on feet		Confusion		Sensitivity to light
	Floating or swimming sensation		Falling/falls		Head pain
	Sensitivity to smells		Loss of consciousness		Feeling like passing out
	Sensitivity to loud sounds		Cataract surgery		Macular degeneration
	Hear your body sounds		Eye patching or surgery		Recent change in eye prescription

How long do the symptoms last?

☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Constant

If your symptoms happen in episodes, how often are the episodes (daily, weekly or monthly)?

_____

Are your episodes more frequent and/or worse over time? _____

Is there anything that makes your symptoms stop or get better? If yes, please describe:

_____

_____

Is there anything that makes your symptoms start or get worse? If yes, please describe:

_____

_____

Does anyone else in your family experience similar symptoms? _____

Have you seen any other healthcare providers for your symptoms? If yes, please attach a list of what specialists you have seen, what tests they did, and what the results of the tests were.

MEDICAL HISTORY

Have you ever experienced the following conditions? If yes, check all that apply.

- ☐ Hearing loss
- ☐ Tinnitus (hearing sounds that aren't actually in the environment)
- ☐ Sensitivity to sounds
- ☐ Pressure or fullness in your ear
- ☐ Ear infections
- ☐ Earache or ear pain
- ☐ Hole in your eardrum
- ☐ Ear surgeries

Do you or have you ever had any of the following conditions? If yes, check all that apply.

	Allergies		High cholesterol
	Anxiety		Kidney disease
	Arthritis		Macular degeneration
	Autoimmune disorder		Migraines or headaches
	Back pain, injury, or surgery		Multiple sclerosis
	Cancer		Neck pain, injury, or surgery
	Dementia or Alzheimer disease		Neuropathy
	Depression		Parkinson disease
	Diabetes		Psychiatric disorder
	Eye disorder		Seizure
	Glaucoma		Stroke
	Heart disease or heart attack		Tingling, numbness, or loss of feeling and sensation
	Head injury		TMJ
	High blood pressure		Vision problems

Have you had any recent illnesses or infections?

_____

Have you been hospitalized or had surgery in the past 5 years?

_____

Please attach list of all your current medications, including prescription drugs, over-the-counter drugs, hormones, herbal supplements, and vitamins. Please include the name of the medication, the dosage/amount, and the how many times you take the medication each day.

LIFESTYLE

Please describe your current work status.

- ☐ Employed
- ☐ Unemployed
- ☐ Unable to work
- ☐ Other (please describe) _____

Have your symptoms interfered with, or made it more difficult, to enjoy your daily life? If yes, check all that apply.

- ☐ Work/employment
- ☐ Social activities/relationships
- ☐ Leisure activities
- ☐ Mobility (getting around the house, going places)
- ☐ Other (please describe) _____

Do you use or consume any of the following substances? If yes, check all that apply.

- ☐ Alcohol
- ☐ Tobacco or cigarettes
- ☐ Caffeine
- ☐ Recreational drugs

Do you exercise regularly? _____

Is there anything else you would like us to know?_____

_____

Thank you for completing this questionnaire. We look forward to working with you towards your best health and wellness.

This case history form was modified using the following resources:

Northern Illinois Speech-Language-Hearing Clinic,
UCSF Medical Center, Vestibular History Form
Vestibular Disorders Association, Dizziness & Balance Med