Wendy Webb Schoenewald, PT, OCS
Kelsey Hanlon, PT, DPT
Jenna McLane, PT, DPT
Joanne Haug, PT
Palak Mulji, PT, DPT
Amanda Nguyen, PT, DPT

Physical Therapy & Vestibular Rehabilitation

Dizzy Medical History

Name: _____ Age: _____ Date: _____

Height:_____ft___in__ **Weight:**_____lbs_

Please complete this form to the best of your ability. If you have any questions, please ask the receptionist.
Have you ever experienced any of the following *(mark in column Y for yes, N for no)*:

	Y	N		Y	N		Y	N
Bladder Difficulties			Headaches			Osteoporosis/Osteopenia		
Bowel Difficulties			Migraine			Recent Fever		
Depression/Anxiety			Hypertension			Seizures		
Diabetes			Lung Disease			Smoker		
Dizziness			Obesity			Taking Steroids		
Sinus Issues			Heart Disease			Joint Surgeries		
Fullness in Ears			Cancer					
Noise in Ears			Circulatory Disorder					
Double Vision			***Circle***:Upper / Lower Extremities					
Allergies			***List:*** _____					

Eye health/surgeries_____ *circle any that apply*: glaucoma macular degeneration cataracts
Past medical history: _____
_____
Previous dizziness episodes_____
Previous therapy_____
_____

Diagnostic tests: ENG Computerized Posturography Hearing VEMP

MRI: Date: _____ Location: _____

List all prescriptions, over-the-counters, herbals, vitamins and dietary supplements:

Name	Dosage	Frequency	Administration (oral, spray, injectable, etc.)

Rate your Dizziness on a scale of 0 to 10 (0 if no symptoms, 10 is enough to severely interfere with function)

at rest 0_____10

with activity 0_____10

Rate your Disequilibruim while:

Standing 0_____10

Walking 0_____10

01/2015