

# Vertigo Test

## Patient Information:

Name:

Date of Birth:

Gender:            Male            Female            Other:

Contact Information:

## Medical History:

Previous history of vertigo or balance disorders:

- Yes
- No

History of head trauma or ear disorders:

- Yes
- No

Any recent changes in hearing or tinnitus:

- Yes
- No

Any other relevant medical conditions:

## Symptoms Checklist:

Please indicate the frequency and severity of the following symptoms experienced in the past month:

### 1. Spinning sensation (vertigo):

- None
- Mild (occasional)
- Moderate (frequent)
- Severe (daily)

**2. Abnormal eye movements (nystagmus):**

- None
- Occasionally noticed
- Frequently noticed
- Always present

**3. Balance problems:**

- None
- Mild (occasional unsteadiness)
- Moderate (difficulty walking)
- Severe (falls or loss of balance)

**4. Nausea or vomiting associated with vertigos:**

- None
- Mild (rarely)
- Moderate (occasionally)
- Severe (frequent)

**5. Sensitivity to movement or changes in head position:**

- None
- Mild (occasional dizziness)
- Moderate (discomfort with specific movements)
- Severe (difficulty with daily activities)

**6. Hearing loss or tinnitus:**

- None
- Occasionally noticed
- Frequently noticed
- Always present

**Diagnostic Tests:**

Based on the symptoms reported, the following diagnostic tests may be indicated:

- Dix-Hallpike maneuver
- Head impulse test
- Audiometric tests
- MRI scan
- Other tests as deemed necessary by the healthcare provider

**Interpretation:****Follow-up:**