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: