CARLS CENTER FOR CLINICAL CARE AND EDUCATION

CENTRAL MICHIGAN UNIVERSITY

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Audiology Vestibular Case History

Patient Name:________________________________ Today's Date:__________________
(Last) (First) (Middle Initial)

Date of Birth (mm/dd/yyyy):______________ MRN:________________
office use only

Health History: (Please check ☑ all that you have or had in the past.)

- ❑ Allergies
- ❑ Sinusitis
- ❑ Meningitis
- ❑ Scarlet Fever or Prolonged Low Fever
- ❑ Prolonged High Fever
- ❑ Mumps
- ❑ Measles
- ❑ Tuberculosis (TB)
- ❑ Cytomegalovirus
- ❑ Syphilis
- ❑ Hepatitis (A, B, or C)
- ❑ Diabetes
- ❑ Arthritis
  ___Rheumatoid or
  ___Osteo
- ❑ Bone Fractures
- ❑ Surgical Joint Replacement
- ❑ Foot Pain
- ❑ Foot De-sensitivity
- ❑ Neuropathy
- ❑ Difficulty Turning or Tipping Head
- ❑ Chronic Pain
- ❑ Neck or Back Problems
- ❑ Tremors/Shaking (hands, arms, feet, legs)

- ❑ Multiple Sclerosis
- ❑ Polio
- ❑ Cerebral Palsy
- ❑ Traumatic Brain Injury/ Head Trauma
- ❑ Concussion or Loss of Consciousness
- ❑ Frequent Severe Headaches or Migraines
- ❑ Alzheimer's disease
- ❑ Dementia
- ❑ Stroke, Brain Attack, TIA or CVA
- ❑ Seizure Disorder
- ❑ Parkinson's disease
- ❑ Huntington's disease
- ❑ Other Neurological
  ____
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Heart Pacemaker with open leads
- ❑ Hypothyroidism
- ❑ Kidney Disease
- ❑ Immune Deficiency Disorder
- ❑ Hyperparathyroidism

- ❑ Eye Disease or Serious Vision Problems
- ❑ Legally Blind/Artificial Eye
- ❑ Wear regular Glasses
  ___reading glasses
  ___bifocals/trifocals
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular Degeneration
- ❑ Diabetic retinopathy
- ❑ Date of Last Vision Exam:
  ____
- ❑ Barotraumas
- ❑ Hearing Loss
- ❑ Hearing aids
- ❑ Ear pain
- ❑ Ear surgery
- ❑ Noise exposure
- ❑ Ear Wax Build-up or Impaction
- ❑ Frequent Ear Infections
- ❑ Skin allergies to adhesive tape, rubbing alcohol, any type of soap or latex
- ❑ Cancer
  Type:_____________________
  When:_____________________

Height ____________ Weight ___________

General Surgeries: ____

____

Head, Neck, Back Injury/Surgery: ____

____

Dates of Injury/Surgery: ____

____

Bone Density Test in the past 2 years: ☐ Yes ☐ No

X-rays with previous spine fracture: ☐ Yes ☐ No

History of Falls &/or Dizziness

Are you afraid of falling? ☐ Yes ☐ No

Have you had any therapy services in the last 12 months? ☐ Yes ☐ No

Number of falls in last 2 **years**: ___________ Number of falls in last 2 **months**:________

Please tell us the date(s) of your most recent falls: ____________________________

____

Did you fall: (Please check ☑ all that apply.)

- ☐ From stairs
- ☐ From or out of building/other structure
- ☐ From slipping, tripping, or stumbling
- ☐ Out of bed
- ☐ While bending over
- ☐ On or from ladders/scaffolding
- ☐ Into hole or other surface opening
- ☐ From collision, pushing, or shoving by/with another person
- ☐ While transferring to chair
- ☐ During a bathroom transfer
- ☐ Other _________________________

Were there injuries? ☐ Yes ☐ No

Please list: ____

____

When you fell:

Were you dizzy? ☐ Yes ☐ No

Was there a loss of balance? ☐ Yes ☐ No

Did you have heart palpitations? ☐ Yes ☐ No

Do you experience: (Please check ☑ all that apply)

☐ Dizziness	☐ Panic	☐ Heart rate changes
☐ Nausea	☐ Lightheadedness	☐Other _________
☐ Unsteadiness	☐ Spinning sensation	________________

When you experience the above symptoms:

Are they sudden? ☐ Yes ☐ No

How often do they occur? ____

When do they begin? ____

How long do they last? ____

How much time between attacks? ______________________________________

How are they provoked? ____

Do your symptoms occur more often in certain positions? ☐ Yes ☐ No

If yes, what positions? ____

Do you experience ringing in your ears? ☐ Yes ☐ No

☐ Constant ☐ Intermittent ☐ Left ear ☐ Right ear ☐ Both ears

Do you experience changes in your hearing? ☐ Yes ☐ No

☐ Left ear ☐ Right ear ☐ Both ears

Do your ears feel full? ☐ Yes ☐ No

☐ Constant ☐ Intermittent ☐ Left ear ☐ Right ear ☐ Both ears

Do you experience motion sickness? ☐ Yes ☐ No

Explain: ____

Nutrition/Hydration History

Do you drink 6-8 glasses of water a day? ☐ Yes ☐ No

Has the amount of food you have eaten declined in the past three months?

☐ Yes ☐ No

If yes, is this due to a loss in appetite? ☐ Yes ☐ No

Have you had any chewing or swallowing problems? ☐ Yes ☐ No

Have you had any digestive problems? ☐ Yes ☐ No

Have you unintentionally gained or lost any weight within the past three months?

☐ Yes ☐ No If yes, how much? __________pounds

How well nourished do you feel?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Malnourished

How many full meals do you eat per day? ________

Do you eat:

Breakfast ☐ Yes ☐ No
Lunch ☐ Yes ☐ No
Dinner ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes, currently ☐ No, but I used to ☐ No, I never drank

If yes, how many drinks do you have? _______ ☐ per day ☐ per week ☐ per month

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Eliminations/Bladder control

Please check ☑ all that apply

- ☐ Uncontrolled urination or slight leakage
- ☐ Occurs during coughing sneezing, laughing, heavy lifting, sudden motions
- ☐ Leakage of urine with sudden urge…. "I have to go NOW!"
- ☐ Bladder feels spastic, uncontrollable
- ☐ Social isolation because of uncontrollable bladder
- ☐ Experience dribbles
- ☐ Incontinence due to mobility problems
- ☐ Incontinence due to past surgery

Home/Environment History

Please check ☑ all that apply

Bathing: ☐ Sponge Bath ☐ Shower ☐ Tub

How often do you bathe?

☐ Daily ☐ 2-3 times / week ☐ Weekly ☐ Less than weekly

Do you have to go up or down stairs to bathe? ☐ Yes ☐ No

Do you get up at night? ☐ Yes ☐ No

☐ Once ☐ 2-3 times ☐ More than 3 times

Do you use lighting when you get up? ☐ Yes ☐ No

Why do you get up at night? ____

Do you have to walk to get your mail? ☐ Yes ☐ No

If yes, how far do you walk? ____

If yes, do you have to go up and down stairs: ☐ Yes ☐ No

If yes, how many? _________

Are there throw rugs in your home? ☐ Yes ☐ No

Do you use a non-slip bath mat? ☐ Yes ☐ No

Do you use grab rails in the bathroom? ☐ Yes ☐ No

Do the stairs in your home have rails ☐ Yes ☐ No ☐ No stairs in my home

What services are currently provided to you in your home?

- ☐ Homemaker service
- ☐ Home delivered meals
- ☐ Grocery service
- ☐ Chore service
- ☐ Transportation services
- ☐ Assistance with Access to Services

Other ____

Please list your hobbies: ____

____