



# 360° Balance

*Specializing in dizziness, balance and hearing disorders.*

## HEALTH HISTORY QUESTIONNAIRE

All of the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

### Social/Health Habits:

- Do you smoke tobacco?  No  Occasionally  Socially  Daily  Heavily  
 Do you drink alcohol?  No  Occasionally  Socially  Daily  Heavily  
 Do you recreational drugs?  No  Occasionally  Socially  Daily  Heavily  
 Do you exercise?  No  Yes  
 If yes, how many days per week? \_\_\_\_\_ minutes/day? \_\_\_\_\_  
 Describe exercise or activity: \_\_\_\_\_

### Employment/Work:

- Work Status:  Unemployed  Working Full-time  Working light duty  Student  
 Homemaker  Working Part-time  Disabled  Retired

Occupation: \_\_\_\_\_

### General Health Status:

- Please rate your health:  Excellent  Good  Fair  Poor  Don't Know  
 Major life Changes (past year):  None  Death in Family  New Job  Divorce  Move

### Family History:

Please check if anyone in your family has or had any of the following:

- Heart disease  High blood pressure  Cancer  Psychological problems  
 Pulmonary/Lung disease  Diabetes  Arthritis  Stroke  
 Osteoporosis  Allergies  Hearing Loss  Vertigo  
 Balance problems  Other: \_\_\_\_\_

### Your Past Medical History:

- No history  Diabetes  Kidney Disease  Parkinson's Disease  
 AIDS  Emphysema  Liver Disease  Prostate Disease  
 Allergies  Epilepsy/Seizures  Low blood pressure  Skin disorders  
 Asthma  Fibromyalgia  Lung disorder  Sleep disorders  
 Arthritis  Glaucoma  Lyme's Disease  Stroke  
 Blood disorders  Heart attack  Macular Degeneration  Thyroid disorders  
 Broken bones  Heart Disease  Meniere's Disease  Ulcers (stomach)  
 Chronic Fatigue Syndrome  Hepatitis  Migraines  Repeated infections  
 Circulation problems  Head Injury  Muscular Dystrophy  Reoccurring Vertigo  
 Cancer  High blood pressure  Multiple Sclerosis  \_\_\_\_\_  
 Cystic Fibrosis  High cholesterol  Osteoporosis  \_\_\_\_\_  
 Depression  Genetic Disease  Pacemaker  \_\_\_\_\_

### For women only:

- Pelvic Inflammatory Disease?  No  Yes  Trouble with period?  No  Yes  
 Complicated pregnancies?  No  Yes  Currently pregnant?  No  Yes  
 Endometriosis?  No  Yes  Other: \_\_\_\_\_  
 Increase in current symptoms with hormonal changes?  No  Yes

## Surgical History:

Please list any surgeries you have had and, if known, include dates:

No surgeries to date

1. \_\_\_\_\_ Date: \_\_\_\_\_ 2. \_\_\_\_\_ Date: \_\_\_\_\_  
3. \_\_\_\_\_ Date: \_\_\_\_\_ 4. \_\_\_\_\_ Date: \_\_\_\_\_

## Symptom Checklist:

Within the last year, have you had any of the following (check all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> No symptoms            | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Syncope (passing out)            |
| <input type="checkbox"/> Bowel problems         | <input type="checkbox"/> Hearing loss           | <input type="checkbox"/> Tinnitus (noises in your ear)    |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Heart palpitations     | <input type="checkbox"/> Tremors                          |
| <input type="checkbox"/> Cough (persistent)     | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Urinary problems                 |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Loss of appetite       | <input type="checkbox"/> Vertigo                          |
| <input type="checkbox"/> Difficulty driving     | <input type="checkbox"/> Loss of balance        | <input type="checkbox"/> Vision problems                  |
| <input type="checkbox"/> Difficulty walking     | <input type="checkbox"/> Motion sickness        | <input type="checkbox"/> Weakness in arms/legs            |
| <input type="checkbox"/> Difficulty sleeping    | <input type="checkbox"/> Nausea/Vomiting        | <input type="checkbox"/> Weight gain (unexplained)        |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Numbness in arms/legs  | <input type="checkbox"/> Weight loss (unexplained)        |
| <input type="checkbox"/> Excessive sweating     | <input type="checkbox"/> Pain at night          | <input type="checkbox"/> Dizziness with loud noises       |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Pressure in your ears  | <input type="checkbox"/> Dizziness with physical exertion |
| <input type="checkbox"/> Foggy headedness       | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Other: _____                     |

## Diagnostic Tests / Measures:

Within the last year, have you had any of the following (check all that apply):

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> No diagnostic testing | <input type="checkbox"/> Bronchoscopy   | <input type="checkbox"/> Hearing tests        | <input type="checkbox"/> Pulmonary Function Test    |
| <input type="checkbox"/> Angiogram             | <input type="checkbox"/> CT scan        | <input type="checkbox"/> Mammogram            | <input type="checkbox"/> Speech/Language evaluation |
| <input type="checkbox"/> Arthroscopy           | <input type="checkbox"/> Ultrasound     | <input type="checkbox"/> MRI                  | <input type="checkbox"/> Stool test                 |
| <input type="checkbox"/> Biopsy                | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Pap smear            | <input type="checkbox"/> Stress test                |
| <input type="checkbox"/> Blood test            | <input type="checkbox"/> EEG            | <input type="checkbox"/> EMG/Nerve conduction | <input type="checkbox"/> Urine test                 |
| <input type="checkbox"/> Bone scan             | <input type="checkbox"/> EKG            | <input type="checkbox"/> ENG                  | <input type="checkbox"/> X-Ray                      |
| <input type="checkbox"/> Other: _____          |   |   |   |

## Medications:

Please check or list all medications or allergies:

### Non-Prescription:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> No medications | <input type="checkbox"/> Decongestants      | <input type="checkbox"/> Motrin            |
| <input type="checkbox"/> Advil/Alleve   | <input type="checkbox"/> Excedrin           | <input type="checkbox"/> Vitamins/minerals |
| <input type="checkbox"/> Antihistamine  | <input type="checkbox"/> Herbal supplements | <input type="checkbox"/> Tylenol           |
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Ibuprofen/Naproxen | <input type="checkbox"/> Other: _____      |

### Prescription:

- No medications  
 \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  
 See attached list

### Allergies:

- Drug allergies:  No  Yes, please list: \_\_\_\_\_  
 Airborne pathogens:  No  Yes, please list: \_\_\_\_\_

Are you receiving any treatment for above stated allergies? If yes, please describe:

\_\_\_\_\_