PHYSICIANS' CLINIC
of Iowa, P.C.

VESTIBULAR THERAPY PATIENT HISTORY FORM

Today's Date _____

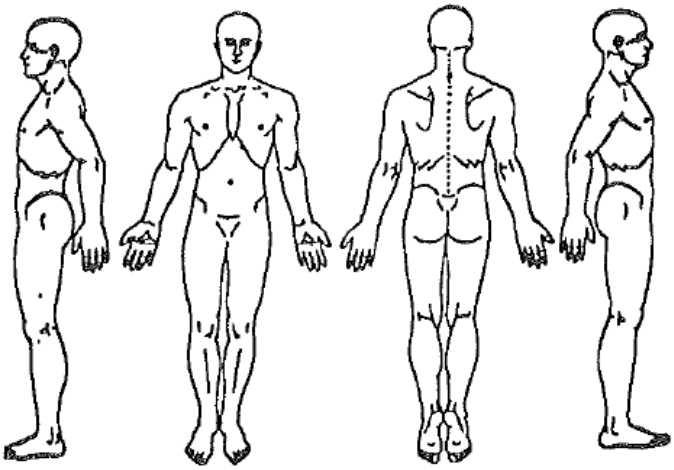
Name _____ DOB _____ Age _____ Height _____ Weight _____

Date of Next Visit with Referring Doctor _____ Family Doctor _____

Employer/Occupation _____ Leisure Activities _____

Describe the reason you are here _____

_____ Date Symptoms Began _____ Date of Surgery _____



Indicate on the diagrams, the area(s) or location(s) where you are currently experiencing symptoms, using the following key:

PPPPP = pins & needles
SSSSS = stabbing
XXXXX = burning
ZZZZZ = deep ache

Have you **EVER** been diagnosed as having any of the following conditions? Please circle.

Cancer	High Blood Pressure	Heart problems	Circulation problems	Blood Clots
Bleeding Disorder	Asthma	Hepatitis	Tuberculosis	Stomach Ulcers
Thyroid problems	Kidney problems	Depression	Diabetes	Multiple Sclerosis
Stroke	Seizures	Rheumatoid Arthritis	Chemical Dependency	
Osteoporosis	Osteoarthritis	COPD/Emphysema	Tobacco use: Y N Amt/day: _____	

Other _____

Please list any surgeries **or** other conditions for which you have been hospitalized, including the approximate date.

_____

Do you have allergies: Y N If yes, please specify _____

Please list any medications you are currently taking (prescription and over the counter). If you have a list, we would be happy to photocopy if for you.

_____

Please circle any of the following symptoms you are experiencing.

nausea/vomiting	fatigue	dizziness/lightheadedness	tremors
fever/chills/sweats	numbness or tingling	seizures	double vision
loss of vision	eye redness	skin rash	problems sleeping
sexual difficulties	hearing problems	joint/muscle swelling	easy bruising
excessive bleeding	difficulty breathing	regular cough	arm/leg swelling
heart racing in your chest	difficulty swallowing	heartburn/indigestion	post menopause
urinary incontinence	blood in urine	pregnant or think you might be	stress at home or work
weight loss/gain	bowel/bladder irregularities	abdominal pain/problems	
blood in stools	menstrual irregularities	night pain or night sweats	

If you circled any of the above, are you under a physician's care for this/these conditions? Y N

Patient Signature _____ *Thank you for taking time to complete this questionnaire.*