Name ______________________________ Date ______________

I. When you are "dizzy" do you experience any of the following sensations? Please read the entire list first. Then put an "x" in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	1. Lightheadedness or Swimming Sensation in the head.
☐	☐	2. Blacking out or loss of consciousness.
☐	☐	3. Unsteadiness.
☐	☐	4. Tendency to fall: To the right?
☐	☐	To the left?
☐	☐	Forward?
☐	☐	Backward?
☐	☐	5. Objects spinning or turning around you.
☐	☐	6. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
☐	☐	7. Loss of balance when walking: Veering to the right?
☐	☐	Veering to the left?
☐	☐	8. Headache.
☐	☐	9. Nausea or vomiting.
☐	☐	10. Pressure in the head.

II. Please check box for either YES or NO and fill in the blank spaces.

YES	NO	
☐	☐	1. My dizziness is constant?
☐	☐	in attacks?
		2. When did dizziness first occur? ______________
		3. If in attacks: How often? ______________
		How long do they last? ______________
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	4. Are you completely free of dizziness between attacks?
☐	☐	5. Does dizziness occur only in certain positions?
☐	☐	6. Do you have trouble walking in the dark?
☐	☐	7. When you are dizzy, must you support yourself when standing?
☐	☐	8. Do you know of any possible cause of your dizziness? What? ______________
		9. Do you know of anything that will:
☐	☐	Stop your dizziness or make it better?
☐	☐	Make your dizziness worse?
☐	☐	Precipitate an attack?
☐	☐	10. Did you have a cold or other illness just prior to onset of dizziness?
☐	☐	11. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?
☐	☐	12. Do you have any allergies? What?
☐	☐	13. Did you ever injure your head? When?
☐	☐	Were you unconscious?
☐	☐	14. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics). What?
☐	☐	15. Do you use tobacco in any form? How much?
☐	☐	16. Do you use alcohol?
☐	☐	17. Have you ever had ear surgery?

(over)

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III. Do you have any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle ear involved.

YES	NO				
☐	☐	1. Difficulty in hearing?	Both ears	Right	Left
		When did this start? ______________________			
☐	☐	Is it getting worse?			
☐	☐	2. Noise in your ears?	Both ears	Right	Left
		Describe the noise ______________________			
☐	☐	Does anything stop the noise or make it better?			
☐	☐	3. Fullness or stuffiness in your ears?	Both ears	Right	Left
☐	☐	Does this change when you are dizzy?			
☐	☐	4. Pain in your ears?	Both ears	Right	Left
☐	☐	5. Discharge from your ears?	Both ears	Right	Left

IV. Have you ever experienced any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	1. Double vision.	Constant	In Episodes
☐	☐	2. Numbness of face or extremities.	Constant	In Episodes
☐	☐	3. Blurred vision or blindness.	Constant	In Episodes
☐	☐	4. Weakness in arms or legs	Constant	In Episodes
☐	☐	5. Clumsiness in arms or legs	Constant	In Episodes
☐	☐	6. Confusion or loss of consciousness.	Constant	In Episodes
☐	☐	7. Difficulty with speech.	Constant	In Episodes
☐	☐	8. Difficulty with swallowing	Constant	In Episodes
☐	☐	9. Tingling around the mouth.	Constant	In Episodes

V. Please check box for either YES or NO.

YES	NO	
☐	☐	1. Do you ever experience a tremor, feeling of faintness or blacking out a few hours after meals?
☐	☐	2. Has any member of your family had diabetes?
☐	☐	3. Does any member of your family have allergies?
☐	☐	4. Do you have diabetes, thyroid disease, liver disease, high blood pressure or pituitary gland disease?
☐	☐	5. Have you ever had syphillis?
☐	☐	6. Have you ever had a neck injury?
☐	☐	7. Have you had any major illness or surgery?
		List ______________________