NAME:_____ **DATE:**_____

1. **When you are "dizzy", do you experience any of the following sensations? Please read the entire list first. Then circle YES or NO to describe your feelings most accurately.**

YES NO 1. Lightheadedness

YES NO 2. Swimming sensation in the head.

YES NO 3. Blacking out

YES NO 4. Loss of consciousness

YES NO 5. Tendency to fall: To the right?
YES NO To the left?
YES NO Forward?
YES NO Backward?

YES NO 6. Objects spinning or turning around you.

YES NO 7. Sensation that you are turning or spinning inside, with outside objects remaining stationary.

YES NO 8. Loss of balance when walking. Veering to the right?
YES NO Veering to the left?

YES NO 9. Headache

YES NO 10. Nausea or vomiting

YES NO 11. Pressure in the head

2. **Please circle YES or NO and fill in the blank spaces.**

YES NO 1. My dizziness is constant?
YES NO In attacks?

YES NO 2. When did dizziness first occur? _____

YES NO 3. If in attacks, How often? _____
How long do they last? _____
YES NO Do you have any warning that the attack is about to start?

YES NO 4. Are you completely free of dizziness between attacks?

YES NO 5. Does dizziness occur only in certain positions?

YES NO 6. Do you have trouble walking in the dark?

YES NO 7. When you are dizzy, must you support yourself when standing?

YES NO 8. Do you know of any possible cause of your dizziness?
What? _____

YES NO 9. Do you know of anything that will:
Stop your dizziness or make it better? _____
Make your dizziness worse? _____
Precipitate an attack? _____

YES NO 10. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?

YES NO 11. Do you have any allergies? _____

YES NO 12. Did you ever injure your head?

YES NO Were you unconscious?

NAME: _____ **DATE:** _____

YES NO 13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbituates, antibiotics)
What: _____

YES NO 14. Do you use tobacco in any form? How much? _____

YES NO 15. Do you use alcohol?

YES NO 16. Have you ever had ear surgery?

3. Do you have any of the following symptoms? Circle YES or NO and circle ear involved.

YES NO 1. Difficulty in hearing? Both Ears Right Left
When did this start? _____
YES NO Is it getting worse? _____

YES NO 2. Noise in your ears? Both Ears Right Left
Describe the noise _____
YES NO Does noise change with dizziness? If so, how? _____
YES NO Does anything stop the noise or make it better? _____

YES NO 3. Fullness or stuffiness in your ears? Both Ears Right Left
YES NO Does this change when you are dizzy?

YES NO 4. Pain in your ears? Both Ears Right Left

YES NO 5. Discharge from your ears? Both Ears Right Left

4. Have you ever experienced any of the following symptoms? Circle YES or NO and circle if Constant or if in Episodes.

YES NO 1. Double vision Constant In Episodes

YES NO 2. Numbness of face or extremities Constant In Episodes

YES NO 3. Blurred vision or blindness Constant In Episodes

YES NO 4. Weakness in arms or legs Constant In Episodes

YES NO 5. Clumsiness in arms or legs Constant In Episodes

YES NO 6. Confusion or loss of consciousness Constant In Episodes

YES NO 7. Difficulty with speech Constant In Episodes

YES NO 8. Difficulty with swallowing Constant In Episodes

YES NO 9. Tingling around the mouth Constant In Episodes

YES NO 10. Spots before the eyes Constant In Episodes

5. Please circle YES or NO

YES NO 1. Do you get dizzy after exertion or overwork?

YES NO 2. Did you get new glasses recently?

YES NO 3. Do you tend to get upset easily?

YES NO 4. Do you get dizzy when you have not eaten for a long time?

YES NO 5. Is your dizziness connected with your menstrual period?

YES NO 6. Have you ever had a neck injury?