

IS YOUR DIZZINESS ASSOCIATED WITH ANY OF THE FOLLOWING SENSATIONS?  
PLEASE READ THE ENTIRE LIST FIRST, THEN CIRCLE YES OR NO TO DESCRIBE YOUR  
FEELINGS MOST ACCURATELY.

Section 1

- Yes No 1. LH or swimming sensation in the head
- Yes No 2. Blacking out or Losing consciousness
- Yes No 3. Tendency to fall
- Yes No 4. Objects spinning or turning around you
- Yes No 5. Sensation that YOU are turning or spinning inside, with outside objects stationary
- Yes No 6. Loss of balance when walking in the light: Veering to the: Right? Left?
- Yes No 7. Loss of balance when walking in the dark: Veering to the: Right? Left?
- Yes No 8. Headache
- Yes No 9. Nausea
- Yes No 10. Vomiting
- Yes No 11. Pressure in the head
- Yes No 12. Tingling in the fingers or toes
- Yes No 13. Tingling around the mouth

Section 2

1. When did your Dizziness first occur? \_\_\_\_\_
2. How often do you become dizzy? \_\_\_\_\_
3. If dizziness occurs in attacks, how long does an attack last? \_\_\_\_\_
- Yes No 4. Do you any warning that dizziness is about to start?
- Yes No 5. Does dizziness occur any particular time of day or night?
- Yes No 6. Are you completely free of dizziness between attacks?
- Yes No 7. Does change of position make you dizzy? Which movements? \_\_\_\_\_
- Yes No 8. Do you become dizzy when rolling over in bed?  
To the Right? \_\_\_\_\_ To the Left? \_\_\_\_\_

Yes No 9. Do you know of any possible cause for your dizziness? What? \_\_\_\_\_  
\_\_\_\_\_

10. Anything that will: stop it? Make it worse?

Yes No a. Stop your dizziness or make it better? \_\_\_\_\_  
\_\_\_\_\_

Yes No b. Make your dizziness worse? \_\_\_\_\_  
\_\_\_\_\_

Yes No 11. Do you become dizzy when you bend your head forward?

Yes No Backward?

Yes No 12. Do you become dizzy when you cough?

Yes No When you sneeze?

Yes No When you have a bowel movement?

13. Can any of these make your dizziness worse or start an attack?

Yes No Fatigue

Yes No Exertion

Yes No Hunger

Yes No Menstrual Period

Yes No Stress

Yes No Emotional upset

Yes No Alcohol

14. Do you have any allergies? What? \_\_\_\_\_

### Section 3

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? PLEASE CIRCLE YES OR NO AND WHICH EAR IS INVOLVED, IF APPLICABLE.

Yes No 1. Dizziness? Describe dizziness \_\_\_\_\_

Yes No 2. Difficulty in hearing? Both Ears Right Left

3. Does your hearing change with dizziness? Yes No

If so, how? \_\_\_\_\_

Yes	No	4. Do you have noise in your ears? Describe the noise: _____	Both Ears	Right	Left
		5. Does noise change with dizziness? If so, how? _____	Yes	No	
Yes	No	6. Do you have fullness or stuffiness in your ears?	Both Ears	Right	Left
Yes	No	7. Do you have pain in your ears?	Both Ears	Right	Left
Yes	No	8. Do you have a discharge from your ears?	Both Ears	Right	Left

#### Section 4

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? PLEASE CIRCLE YES OR NO AND CIRCLE IF CONSTANT OR IN EPISODES.

Yes	No	1. Double Vision	Constant	In Episodes
Yes	No	2. Blurred vision	Constant	In Episodes
Yes	No	3. Blindness	Constant	In Episodes
Yes	No	4. Numbness in face or extremities	Constant	In Episodes
Yes	No	5. Weakness in the arms or legs	Constant	In Episodes
Yes	No	6. Clumsiness in the arms or legs	Constant	In Episodes
Yes	No	7. Confusion, or loss of consciousness	Constant	In Episodes
Yes	No	8. Difficulty with speech	Constant	In Episodes
Yes	No	9. Difficulty with swallowing	Constant	In Episodes
Yes	No	10. Pain in neck or shoulders	Constant	In Episodes

#### Section 5

Yes	No	Past and family history
Yes	No	1. Do you have a history of earaches or ear infections as a child?
Yes	No	2. Did you ever injure your head? When? _____
Yes	No	3. Were you ever unconscious? When? _____
Yes	No	4. Did you suffer from Motion sickness before age 12?
Yes	No	5. Have you suffered from motion sickness in the last 10 years?

Yes No 6. Do you now take medications regularly? What? \_\_\_\_\_  
\_\_\_\_\_

Yes No 7. Have you taken medications in the past for dizziness? Which ones?  
\_\_\_\_\_  
\_\_\_\_\_

Yes No 8. Do you have a past medical history of: (Circle All that Apply)  
Diabetes Heart Disease Thyroid Disease Kidney Disease High Blood Pressure  
Migraine Rheumatoid Arthritis Multiple Sclerosis IBS Ulcerative Colitis

Yes No 9. Do you have a family history of: (Circle all that apply) Ear disease  
Neurological disease Migraine Autoimmune Conditions

Yes No 10. Does caffeine affect your dizziness? How? \_\_\_\_\_  
\_\_\_\_\_

Yes No 11. Does alcohol affect your dizziness? How? \_\_\_\_\_  
\_\_\_\_\_