



- |  |     |    |
|--|-----|----|
| 6. Does change of position make you dizzy?   | YES | NO |
| 7. Do you have trouble walking in the dark?  | YES | NO |
| 8. When dizzy, can you stand up unsupported?   | YES | NO |
| 9. Do you know any possible causes of the dizziness?   | YES | NO |
| 10. Do you know anything that will:  |     |    |
| a. stop your dizziness?  | YES | NO |
| b. make your dizziness better?   | YES | NO |
| If so what? _____  |     |    |
| c. bring on an attack?   | YES | NO |
| If yes, what? _____  |     |    |
| 11. Is there a relationship between eating and your dizziness?   | YES | NO |
| 12. Were you exposed to any irritating fumes, paints, etc. at the time of the onset of your dizziness? | YES | NO |
| If yes, what? _____  |     |    |
| 13. Do you have allergies?   | YES | NO |
| 14. Did you ever injure your head?   | YES | NO |
| If yes, please describe: _____   |     |    |
| 15. Do you take medications regularly?   | YES | NO |
| If yes, please list: _____   |     |    |
| 16. Do you use tobacco in any form?  | YES | NO |
| If yes, how much? _____  |     |    |
| 17. Do you feel that you are under undue stress?   | YES | NO |
| 18. Do you drink alcohol?  | YES | NO |
| If yes, how much? _____  |     |    |
| 19. Has anyone in your family had similar dizziness?   | YES | NO |
| If yes, who? _____   |     |    |

**III. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS ASSOCIATED WITH EARS?**

- |  |           |          |           |      |
|--|-----------|----------|-----------|------|
| 1. Difficulty in hearing?                              | Right Ear | Left Ear | Both Ears | None |
| 2. Noise in your ear?                                  | Right Ear | Left Ear | Both Ears | None |
| 3. Fullness, stuffiness or pressure in your ears?      |           |          |           |      |
| 4. Pain in ears?                                       | Right Ear | Left Ear | Both Ears | None |
| 5. Discharge from ear?                                 | Right Ear | Left Ear | Both Ears | None |
| 6. Do any of these symptoms change with the dizziness? |           |          | Yes       | No   |
| If yes, please describe: _____                         |           |          |           |      |
| 7. Have you ever been exposed to loud noise?           |           |          | Yes       | No   |
| If yes, when and for how long? _____                   |           |          |           |      |
| 8. Has anyone in your family had hearing problems?     |           |          | Yes       | No   |
| If yes, please explain: _____                          |           |          |           |      |

**IV. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?**

1. Double Vision	YES	NO	CONSTANT	EPISODIC
2. Blurred Vision	YES	NO	CONSTANT	EPISODIC
3. Blindness	YES	NO	CONSTANT	EPISODIC
4. Numbness of face	YES	NO	CONSTANT	EPISODIC
5. Numbness of arms or legs	YES	NO	CONSTANT	EPISODIC
6. Weakness of arms or legs	YES	NO	CONSTANT	EPISODIC
7. Clumsiness of arm or legs	YES	NO	CONSTANT	EPISODIC
8. Mental confusion	YES	NO	CONSTANT	EPISODIC
9. Loss of consciousness	YES	NO	CONSTANT	EPISODIC
10. Difficulty swallowing	YES	NO	CONSTANT	EPISODIC

**Thank you for taking the time to fill out this form. Please be sure that you have answered all questions. This will assist in the final report and assessment of results.**

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