Please answer all questions

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 ___ for YES in the second ___ for NO to describe your feelings most accurately.

YES NO
___ ___ 1. Lightheadedness
___ ___ 2. Swimming sensation in the head
___ ___ 3. Objects turn around and around you
___ ___ 4. Sensation that everything is floating
___ ___ 5. Loss of balance or tendency to fall; to right, left, forward, backward
___ ___ 6. Loss of consciousness or blacking out
___ ___ 7. Pressure in ears or head

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

YES NO
___ ___ 1. My dizziness is constant
___ ___ 2. My dizziness comes in attacks
   How often? (Estimate and circle one) one time each year, once per month, once per week.
   How long do they last? __________ hours __________ minutes.
   When did your first attack occur?
   ______________________________________________________________________
   Tell in your own words what happened:
   ______________________________________________________________________
   ______________________________________________________________________
___ ___ 3. My dizziness has awakened me in the night.
___ ___ 4. Can you tell when an attack is about to start?
___ ___ 5. Are you completely free of dizziness between attacks?
___ ___ 6. Do you have nausea with attacks?
___ ___ 7. Do you have vomiting with attacks?
___ ___ 8. When you are dizzy can you stand unsupported?
___ ___ 9. Do you know any possible cause for your dizziness?
   What? ________________________________________________________________
___ ___ 10. Does change of position make you dizzy?
___ ___ 11. Are you worse in the spring or fall?
___ ___ 12. Do you have allergies?
___ ___ 13. Have you ever had a severe head injury?
___ ___ 14. Do you use tobacco? How much? ____________________________
___ ___ 15. Do you use alcohol? How much? ____________________________
III. Do you have any of the following symptoms? Check either YES or NO and Circle ear involved.

YES  NO
___   ___  1. Difficulty hearing?  Both ears  Right  Left
___   ___  2. Noise in your ears?  Both ears  Right  Left
            Describe the noise? ______________________________
___   ___  3. Does the noise change before, after or during times of dizziness?
___   ___  4. Fluctuating hearing between better or worse?  Right  Left
___   ___  5. Do you have pressure or stuffiness in your ears?  Both ears  Right  Left

IV. Please check either YES or NO and Circle either CONSTANT or IN EPISODES if yes

YES  NO
___   ___  1. Double vision?  CONSTANT  IN EPISODES
___   ___  2. Numbness of face, legs or arms?  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. Difficulty walking in the dark?  CONSTANT  IN EPISODES

V. Answer YES or NO

YES  NO
___   ___  1. Have you ever had heart trouble?
___   ___  2. Do you have high blood pressure?
___   ___  3. Have you ever had a stroke?
___   ___  4. Have you ever had syphilis?
___   ___  5. Do you have diabetes?
___   ___  6. Do you suddenly “run out of steam”, get jittery or excessively tired in mid-morning, mid-afternoon?
___   ___  7. Does food relieve this symptom?  Rapidly  Slowly
___   ___  8. Have you ever had water retention before your menstrual period?
___   ___  9. Have you ever had thyroid treatments?