Name:_____ Date:_____

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?		