

NAME: _____ **DATE:** _____

YES NO

13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics)
What: _____

14. Do you use tobacco in any form? How much? _____

15. Do you use alcohol?

16. Have you ever had ear surgery?

III. Do you have any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle ear involved.

YES NO

1. Difficulty in hearing? Both Ears Right Left
When did this start? _____

Is it getting worse? _____

2. Noise in your ears? Both Ears Right Left
Describe the noise _____

Does noise change with dizziness? If so, how? _____

Does anything stop the noise or make it better? _____

3. Fullness or stuffiness in your ears? Both Ears Right Left

Does this change when you are dizzy?

4. Pain in your ears? Both Ears Right Left

5. Discharge from your ears? Both Ears Right Left

IV. Have you ever experienced any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle if Constant or if in Episodes.

YES NO

1. Double vision Constant In Episodes

2. Numbness of face or extremities 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. Tingling around the mouth Constant In Episodes

10. Spots before the eyes Constant In Episodes

V. Please check box for either YES or NO

YES NO

1. Do you get dizzy after exertion or overwork?

2. Did you get new glasses recently?

3. Do you tend to get upset easily?

4. Do you get dizzy when you have not eaten for a long time?

5. Is your dizziness connected with your menstrual period?

6. Have you ever had a neck injury?