

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

YES NO

- | | | |
|-------|-----|---|
| ___ | ___ | 1. My dizziness is constant |
| ___ | ___ | in attacks |
| | | 2. If in attacks: How often? _____
How long do they last? _____ |
| | | 3. How did dizziness first occur? _____ |
| ___ | ___ | 4. Can you tell when an attack is about to start? |
| ___ | ___ | 5. Are completely free of dizziness between attacks? |
| ___ | ___ | 6. Does change of position make you dizzy? |
| ___ | ___ | 7. Do you have any trouble walking in the dark? |
| ___ | ___ | 8. When you are dizzy, can you stand up unsupported? |
| ___ | ___ | 9. Do you know of any possible cause of your dizziness?
What? _____ |
| ___ | ___ | 10. Do you know of anything that will:
Stop your dizziness or make it better? |
| ___ | ___ | Make your dizziness worse? |
| ___ | ___ | Bring on an attack? |
| ___ | ___ | 11. Were you exposed to any irritating fumes, paints, etc., at the onset of
dizziness? |
| ___ | ___ | 12. Do you have any allergies? |
| ___ | ___ | 13. Did you ever injure your head? |
| ___ | ___ | If so, were you unconscious? |
| ___ | ___ | 14. Do you take any medications regularly?
What? _____ |
| <hr/> | | |
| ___ | ___ | 15. Do you use tobacco in any form?
How much? _____ |
| <hr/> | | |

III. Do you have any of the following symptoms? Check either YES or NO and CIRCLE the ear involved.

YES NO

___ ___ 1. Difficulty in hearing? Both ears Right Left

___ ___ 2. Noise in your ears? Both ears Right Left

Describe the noise _____

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

___ ___ 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 experienced any of the following symptoms? Please check either YES or NO and CIRCLE either CONSTANT or 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

V. Have you had any of the following problems? Please check the line for either YES or NO and fill in the blank spaces.

YES NO

- | | | |
|-----|-----|---------------------------------|
| ___ | ___ | 1. Family history of headaches? |
| ___ | ___ | 2. Do you have headaches? |
| ___ | ___ | 3. How often? _____ |
| ___ | ___ | 4. Duration? _____ |
| ___ | ___ | 5. Type of headache? |
| ___ | ___ | Muscle tension |
| ___ | ___ | Sinus |
| ___ | ___ | Migraine |
| ___ | ___ | Other |
| ___ | ___ | 6. Location |
| ___ | ___ | Face |
| ___ | ___ | Eye |
| ___ | ___ | Head |
| ___ | ___ | Neck |
| ___ | ___ | Side, right |
| ___ | ___ | Side, left |
| ___ | ___ | Side, both |
| ___ | ___ | Side, alternates |
| ___ | ___ | 7. Symptoms |
| ___ | ___ | Pressure? |
| ___ | ___ | Throbbing? |
| ___ | ___ | Runny nose? |

YES NO

PG 5

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tearing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Light sensitivity? |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision? |
| <input type="checkbox"/> | <input type="checkbox"/> | Flickering lights? |
| <input type="checkbox"/> | <input type="checkbox"/> | Halo around lights? |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea? |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting? |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain/cramps? |

8. Treatment

What relieves your headaches?

- | | | |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rest? |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep? |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication? |

Type of Medicine _____

9. Association of headache with dizziness

- | | | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Before dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | During dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | After dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Not related? |