





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

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- Tearing?
- Light sensitivity?
- Blurred vision?
- Flickering lights?
- Halo around lights?
- Nausea?
- Vomiting?
- Stomach pain/cramps?

8. Treatment

What relieves your headaches?

- Rest?
- Sleep?
- Medication?
- Type of Medicine \_\_\_\_\_

9. Association of headache with dizziness

- Before dizziness?
- During dizziness?
- After dizziness?
- Not related?