

- Yes No 10. Do you know of anything that will:
Stop your dizziness or make it better?
Make you dizziness worse?
- Yes No 11. Do you have any allergies?
List types: _____
- Yes No 12. Did you ever injure your head?
If so were you unconscious?
- Yes No 13. Do you take any medications regularly?
List types: _____
- Yes No 14. Do you use tobacco in any form?
How much? _____
How often? _____

III. Do you have any of the following symptoms? Please circle yes or no, and circle ear involved.

- Yes No 1. Difficulty hearing. Both ears Right Left
- Yes No 2. Noise in your ears. Both ears Right Left
If so, describe the noise: _____
Does the noise change with dizziness?
If so, how? _____
- Yes No 3. Fullness or stuffiness in ears? Both ears Right Left
- Yes No 4. Pain in your ears. Both ears Right Left
- Yes No 5. Discharge from ears. Both ears Right Left

IV. Have you experienced any of the following symptoms? Please circle yes or no, and circle if constant or if in episodes.

- Yes No 1. Double vision, blurred vision, or blindness. Constant In episodes
- Yes No 2. Numbness of face or extremities. Constant In episodes
- Yes No 3. Weakness in arms or legs. Constant In episodes
- Yes No 4. Clumsiness in arms or legs. Constant In episodes
- Yes No 5. Confusion or loss of consciousness. Constant In episodes
- Yes No 6. Difficulty swallowing. Constant In episodes
- Yes No 7. Difficulty with speech. Constant In episodes
- Yes No 8. Pain in neck or shoulder. Constant In episodes

Patient Signature

Date