

Dizziness Study (continued)

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|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have any allergies? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Did you ever injure your head? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you unconscious? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics). What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you use tobacco in any form? How much? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you use alcohol? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

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|--------------------------|--------------------------|---|-----------|-------|------|
| YES | NO | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Difficulty in hearing? | Both ears | Right | Left |
| | | When did this start? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Is it getting worse? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Noise in your ears? | Both ears | Right | Left |
| | | Describe the noise _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does noise change with dizziness? If so, how? _____ | | | |
| | | Does anything stop the noise or make it better? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Fullness or stuffiness in your ears? | Both ears | Right | Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything stop the noise or make it better? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Pain in your ears? | Both ears | Right | Left |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

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|--------------------------|--------------------------|---------------------------------------|----------|-------------|
| YES | NO | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Double Vision | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Numbness of face or extremities | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Blurred Vision or blindness | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Weakness in arms or legs | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Clumsiness in arms or legs | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Confusion or loss of consciousness | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Difficulty with speech | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Difficulty with swallowing | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Tingling around the mouth | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Spots before the eyes. | Constant | In Episodes |

V. Please check box for either YES or NO.

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|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you get dizzy after exertion or overwork? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Did you get new glasses recently? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you tend to get upset easily? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you get dizzy when you have not eaten for a long time? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Is your dizziness connected with you menstrual period? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever had a neck injury? |