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| --- | --- |
| Referred By:(required) |   |

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| --- | --- |
| 12. When did the dizziness first occur?(required) |   |

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| --- | --- |
| 13. What does the dizziness feel like?(required) |   |

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| --- | --- |
| 14. Is the dizziness CONSTANT or does it come in ATTACKS?(required) |   |

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|  |
| --- |
| Constant |
| Attacks |

 |
| Additional Comments: |
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| --- | --- |
| 15. If the dizziness comes in attacks, how often do these attacks occur? |  |

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| --- |
| Daily |
| Weekly |
| Monthly |
| Other |

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| Additional Comments: |
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| --- | --- |
| 16. If the dizziness occurs in attacks, how long do the attacks last? |  |

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| --- |
| Less than one minute |
| 1 - 5 minutes |
| 6 minutes - 1 hour |
| Several hours |
| One day |
| Several days |
| Other |

 |
| Additional Comments: |
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| --- | --- |
| 17. What factors provoke the dizziness or make the dizziness worse? |  |

 |
| Sitting up / Lying back |
| Rolling over |
| Looking up / down |
| Quick head turns |
| Objects moving by |
| Other |
| Additional Comments: |
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| --- | --- |
| 18. Does anything make the dizziness better? If Yes, briefly explain. |  |

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| --- |
| Yes |
| No |

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| Additional Comments: |
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| --- | --- |
| 19. Does your hearing change when the dizziness occurs?(required) |   |

 |
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|  |
| --- |
| Yes - Both Ears |
| Yes - Right Ear Only |
| Yes - Left Ear Only |
| No |

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| --- | --- |
| 20. If your dizziness occurs in episodes, are you completely free of dizziness between attacks? If NO, briefly explain. |  |

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|  |
| --- |
| Yes |
| No |

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| Additional Comments: |
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| --- | --- |
| 21. Are there any other symptoms associated with the dizziness such as visual changes, numbness or tingling in the arms or legs, weakness in the arms or legs, changes in speech? |  |

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| --- | --- |
| 22. Do you have any history of neurological disease such as migraine, multiple sclerosis, or stroke? If YES, please explain. |  |

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| --- |
| Yes |
| No |

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| Additional Comments: |
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| --- | --- |
| 23. Do you have any difficulty hearing, or have you ever been diagnosed with hearing loss?(required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |
|  |
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| --- | --- |
| 24. Do you have any ringing, buzzing, or humming in your ears (tinnitus)?(required) |   |

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|  |
| --- |
| Yes, both ears |
| Yes, right ear only |
| Yes, left ear only |
| No |

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| Additional Comments: |
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| --- | --- |
| 25. If yes, is the ringing/buzzing/humming constant, or does it fluctuate? |  |

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|  |
| --- |
| Constant |
| Fluctuates |

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| --- | --- |
| 26. If yes, does the ringing/buzzing/humming typically accompany the dizziness? |  |

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| --- |
| Yes |
| No |

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| Additional Comments: |
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| --- | --- |
| 27. Have you experienced plugged ear(s)?(required) |   |

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|  |
| --- |
| Yes, both ears |
| Yes, right ear only |
| Yes, left ear only |
| No |

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| Additional Comments: |
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|  |  |
| --- | --- |
| 28. Have you experienced any ear pain?(required) |   |

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|

|  |
| --- |
| Yes, both ears |
| Yes, right ear only |
| Yes, left ear only |
| No |

 |
| Additional Comments: |
| U,{27b9d831-c2ef-413a-9bb2-ce1c58b54f67}{204},3.125,3.125 |
|

|  |  |
| --- | --- |
| 29. Have you ever been exposed to loud noise (work, recreation, Military service)? If Yes, briefly explain.(required) |   |

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|

|  |
| --- |
| Yes |
| No |

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| Additional Comments: |
| U,{0a82f66f-5d79-44c7-9364-ce092794a3e8}{17},3.125,3.125 |
|

|  |  |
| --- | --- |
| 30. Have you ever had surgery on your ear(s), nose, throat, neck or, head? If YES, briefly explain.(required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |
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| --- | --- |
| 31. Have you been seen by an Ear, Nose, & Throat (ENT) specialist? If yes, briefly explain. (required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |
|  |
|

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| --- | --- |
| 32. Do you currently take any medications? If so, please list.(required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |
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| 33. Have you followed the restrictions prior to testing? (No caffeine for 24 hours, no alcohol for 48 hours, no anti-dizziness medications for 48 hours)(required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |
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| --- | --- |
| 34. Is there anything else you would like us to know?(required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |