|  |  |  |
| --- | --- | --- |
| |  |  | | --- | --- | | Referred By:(required) |  | |
|  |
|  |
| |  |  | | --- | --- | | 12. When did the dizziness first occur?(required) |  | |
|  |
|  |
| |  |  | | --- | --- | | 13. What does the dizziness feel like?(required) |  | |
|  |
|  |
| |  |  | | --- | --- | | 14. Is the dizziness CONSTANT or does it come in ATTACKS?(required) |  | |
| |  | | --- | | Constant | | Attacks | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 15. If the dizziness comes in attacks, how often do these attacks occur? |  | |
| |  | | --- | | Daily | | Weekly | | Monthly | | Other | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 16. If the dizziness occurs in attacks, how long do the attacks last? |  | |
| |  | | --- | | Less than one minute | | 1 - 5 minutes | | 6 minutes - 1 hour | | Several hours | | One day | | Several days | | Other | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 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: |
|  |
| |  |  | | --- | --- | | 18. Does anything make the dizziness better? If Yes, briefly explain. |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 19. Does your hearing change when the dizziness occurs?(required) |  | |
| |  | | --- | | Yes - Both Ears | | Yes - Right Ear Only | | Yes - Left Ear Only | | No | |
|  |
| |  |  | | --- | --- | | 20. If your dizziness occurs in episodes, are you completely free of dizziness between attacks? If NO, briefly explain. |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 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? |  | |
|  |
|  |
| |  |  | | --- | --- | | 22. Do you have any history of neurological disease such as migraine, multiple sclerosis, or stroke? If YES, please explain. |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 23. Do you have any difficulty hearing, or have you ever been diagnosed with hearing loss?(required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 24. Do you have any ringing, buzzing, or humming in your ears (tinnitus)?(required) |  | |
| |  | | --- | | Yes, both ears | | Yes, right ear only | | Yes, left ear only | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 25. If yes, is the ringing/buzzing/humming constant, or does it fluctuate? |  | |
| |  | | --- | | Constant | | Fluctuates | |
|  |
| |  |  | | --- | --- | | 26. If yes, does the ringing/buzzing/humming typically accompany the dizziness? |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 27. Have you experienced plugged ear(s)?(required) |  | |
| |  | | --- | | Yes, both ears | | Yes, right ear only | | Yes, left ear only | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 28. Have you experienced any ear pain?(required) |  | |
| |  | | --- | | 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) |  | |
| |  | | --- | | Yes | | No | |
| 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) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 31. Have you been seen by an Ear, Nose, & Throat (ENT) specialist? If yes, briefly explain. (required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 32. Do you currently take any medications? If so, please list.(required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 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) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 34. Is there anything else you would like us to know?(required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |