

Throbbing?	YES	NO
Light or sound sensitivity?	YES	NO
Motion sickness as a child?	YES	NO
Headaches with caffeine withdrawal?	YES	NO
Any double or blurry vision?	YES	NO
Numbness in your face or extremities?	YES	NO
Weakness or clumsiness in arms, legs?	YES	NO
Slurred or difficult speech?	YES	NO
Difficulty swallowing?	YES	NO
Tingling around your mouth?	YES	NO
Spots before your eyes?	YES	NO
Jerking of arms or legs?	YES	NO
Seizures?	YES	NO
Confusion or memory loss?	YES	NO
Recent head trauma? (if yes, please explain)	YES	NO
3. Have you ever been diagnosed with migraines?	YES	NO

The following refer to your ears and hearing. Please indicate which side has been affected.

Difficulty hearing?	YES	LEFT	RIGHT	BOTH	NO
Ringling or other noises in your ear(s)?	YES	LEFT	RIGHT	BOTH	NO
Fullness in your ear(s)?	YES	LEFT	RIGHT	BOTH	NO
Change in hearing when dizzy?	How?				NO
Pain in your ears?	YES	LEFT	RIGHT	BOTH	NO
Discharge from your ears?	YES	LEFT	RIGHT	BOTH	NO
Hearing improved?	YES	LEFT	RIGHT	BOTH	NO
Hearing worsened?	YES	LEFT	RIGHT	BOTH	NO
Exposure to loud noises?	YES	LEFT	RIGHT	BOTH	NO
Previous ear infections?	YES	LEFT	RIGHT	BOTH	NO
Previous ear surgery?	YES	LEFT	RIGHT	BOTH	NO
What surgery?					
Family history of deafness?	YES				NO
Who?					

The following refer to habits and lifestyle:

1. Is there added stress to your life recently?	YES	NO
2. Are you dizzy or unsteady constantly?	YES	NO
3. Is your dizziness related to moments of stress?	YES	NO
4. Is your dizziness related to your menstrual period?	YES	NO
5. Is your dizziness related to overwork or exertion?	YES	NO
6. Do you feel lightheaded or have a swimming sensation when you are dizzy?	YES	NO

7. Do you find yourself breathing faster or deeper when excited or dizzy?	YES	NO
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