



**B) Do you have any of the following symptoms?**

*Place a check in the box for YES or NO and circle the ear involved.*

Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in hearing?	Both ears	Right	Left
			When did it start? _____		
<input type="checkbox"/>	<input type="checkbox"/>		Is it getting worse?		
<input type="checkbox"/>	<input type="checkbox"/>	Noise in your ears?	Both ears	Right	Left
			Describe the noise _____		
<input type="checkbox"/>	<input type="checkbox"/>		Does the noise change with the dizziness? If so, explain _____		
<input type="checkbox"/>	<input type="checkbox"/>	Does anything stop the noise or make it better?			
<input type="checkbox"/>	<input type="checkbox"/>	Is there fullness or stuffiness in your ears?	Both ears	Right	Left
<input type="checkbox"/>	<input type="checkbox"/>		If so, does this change when you are dizzy?		
<input type="checkbox"/>	<input type="checkbox"/>	Is there pain in your ears?	Both ears	Right	Left
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from your ears?	Both ears	Right	Left

**C) Have you ever experienced any of the following symptoms?**

*Place a check in the box for YES or NO and circle if constant or in episodes.*

<input type="checkbox"/>	<input type="checkbox"/>	Double vision?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Numbness of face or extremities?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or blindness?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness in arms or legs?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Confusion or loss of consciousness?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with speech?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with swallowing?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Tingling around the mouth?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Spots before your eyes?	Constant	Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy after exertion or overwork?		
<input type="checkbox"/>	<input type="checkbox"/>	Did you get new glasses recently?		
<input type="checkbox"/>	<input type="checkbox"/>	Do you tend to get upset easily?		
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you have not eaten for a long time?		
<input type="checkbox"/>	<input type="checkbox"/>	Is your dizziness connected with your menstrual period?		
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a neck injury?		

**D) Please let us know of anything else that you feel could help, that we have not asked you.** \_\_\_\_\_

\_\_\_\_\_

Patient Name \_\_\_\_\_

Chart # \_\_\_\_\_