

11. Do you take any medications regularly?
- | | | | |
|------------------------------|--------|------------------|--------|
| i. Allergy pills? | Yes/No | Tranquilizers? | Yes/No |
| ii. Decongestants? | Yes/No | Pain pills? | Yes/No |
| iii. Antihistamines? | Yes/No | Antibiotics? | Yes/No |
| iv. Aspirin? | Yes/No | Dizziness pills? | Yes/No |
| v. High blood pressure meds? | | Yes/No | |
12. Have you had any intravenous (IV) antibiotics or chemotherapy?
13. Do you suffer easily from motion sickness?
14. Do you experience migraines?
15. Do you have neck/back discomfort or injury?
16. Circle any that apply:
17. Vision problems? heart problems? High blood pressure?
diabetes?

III. Check the appropriate box if you have had any of the following:

	RIGHT EAR	LEFT EAR	BOTH EARS
Hearing loss			
Difference in pitch of sounds			
Distortion of hearing			
Noise in ears			
Fullness or pressure in your ear			
Pain in your ear			
Drainage from your ear			
	RIGHT EYE	LEFT EYE	BOTH EYES
Blurred vision			
Double vision			
	RIGHT	LEFT	BOTH
Numbness in hands or feet			
Weakness in arms or legs			
	YES	NO	
Tingling around mouth or face			
Loss of consciousness or blackouts			
Fainting			
Convulsion or seizure			
Hyperventilate before symptoms			

IV. Vertigo Functional Level Scale:

Check the **best choice** that best applies regarding your current state of overall function, not just during attacks:

_____ 1. My dizziness has no effect on my activities at all.

_____ 2. When I am dizzy I have to stop what I am doing for a while, but it soon passes and I can resume activities. I continue to work, drive, and engage in any activity I choose without restriction. I have not changed any plans of activities to accommodate my dizziness.

_____ 3. When I am dizzy, I have to stop what I am doing for a while, but it does pass and I can resume activities. I continue to work, drive, and engage in most activities I choose, but I have had to change some plans and make some allowance for my dizziness.

_____ 4. I am able to work, drive, travel, take care of a family, or engage in most activities, but I must exert a great deal of effort to do so. I must constantly make adjustments in my activities and budget my energies. I am barely making it.

_____ 5. I am unable to work, drive, or take care of a family. I am unable to do most of the active things that I used to. Even essential activities must be limited. I am disabled.

_____ 6. I have been disabled for 1 year or longer and/or I receive compensation (money) because of my dizziness or balance problem.

Any other information we didn't ask about that you would like us to know about your condition:
