DIZZINESS HISTORY

Please complete this questionnaire and bring it with you on the day of your testing.

1. When was the first time you experienced your symptoms?

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2. Was the onset of your symptoms sudden and severe or did they come on gradually?

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3. Has the frequency and/or intensity of your symptom changed or fluctuated since onset? How?

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4. How would you describe your symptom? (For example; lightheadedness, off-balance, spinning, etc)

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5. Are your symptoms constant or do they come and go? How long do they last when they are present?

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6. Are you completely free of symptoms between attacks? If not, how do you feel between attacks? (For example; tires, unsteady, nauseous, etc)

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7. Can you tell when an attack is about to start? How?

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8. Do certain head or body movements or position changes seem to cause your symptoms or cause them to change? If so, what types of movements? (For example; walking, bending down, lying down in bed, etc)

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9. Do you have any neck, back or leg problems? (For example; herniated disk, knee replacement)

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10. Which of these best describe your activity level when your symptoms are worst?

   a) I am able to go on with my usual activities.
   b) I am able to go on with my usually activities using caution.
   c) I am able to go on with only some of my usual activities.
   d) I am unable to go on with most of my usual activities.
   e) I am completely incapacitated and must go to bed.

11. Do you now or have you in the past ever had migraine headaches or other severe headaches?

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12. Do you have problem with motion sickness? _______________________________________________

13. Do certain stimuli cause significant discomfort? (For example; bright lights, loud sounds, strong odors, etc) Please be specific.

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14. Please circle any of the symptom or conditions that you currently experience:

- hearing loss (R/L)
- noise in ears (R/L)
- drainage from ears (R/L)
- fullness in ears (R/L)
- pain in ears (R/L)
- pressure in head
- blurred vision
- blindness
- double vision
- weakness in arms/legs
- numbness in face
- numbness in fingers/toes
- loss of consciousness
- memory loss
- rapid heartbeat
- shortness of breath
- diabetes
- allergies
- sinus problems
- high blood pressure
- heart/circulation problems

15. Please circle any of these symptoms or conditions you have experienced in the past:

- concussion
- skull fracture
- whiplash
- heart attack
- stroke
- allergies
- sinus problems
- mini stroke (TIA)
- seizure
- thyroid problems
- cancer

16. Please list any major injuries, illnesses or surgeries you have had:

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17. Please list all medications you take regularly:

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18. Please provide any other information you feel is relevant to your condition:

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