

NAME _____ DATE: _____

VNG HISTORY FORM

I. WHEN YOU ARE DIZZY, DO YOU EXPERIENCE ANY OF THE FOLLOWING SENSATIONS? (PLEASE READ THE ENTIRE LIST FIRST; CIRCLE THE NUMBERS OF THOSE, WHICH DESCRIBE YOUR FEELINGS MOST ACCURATELY).

1. LIGHTHEADEDNESS
2. TENDENCY TO LOSE BALANCE OR FALL
3. OBJECTS SPINNING OR TURNING AROUND YOU
4. HEADACHE
5. NAUSEA OR VOMITING
6. PRESSURE IN THE HEAD
7. FLUCTUATION IN HEARING

II. PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. IS YOUR DIZZINESS CONSTANT?	YES	NO
2. DOES IT COME IN ATTACKS?	YES	NO
3. HOW OFTEN DO THE ATTACKS OCCUR? _____		
4. HOW LONG ARE THE ATTACKS? _____		
5. WHEN DID THE DIZZINESS FIRST OCCUR? _____		
6. DOES THE DIZZINESS ONLY OCCUR IN CERTAIN POSITIONS?	YES	NO
a. WHEN UPRIGHT?	YES	NO
b. WHEN LYING FLAT?	YES	NO
c. TURNING TO THE RIGHT?	YES	NO
d. TURNING TO THE LEFT?	YES	NO
e. SITTING OR STANDING UP RAPIDLY?	YES	NO
f. LOOKING UP RAPIDLY?	YES	NO
7. DO YOU KNOW ANYTHING THAT WILL:		
a. STOP THE DIZZINESS OR MAKE IT GO AWAY?	YES	NO
b. MAKE YOUR DIZZINESS WORSE?	YES	NO
8. HAVE YOU EVER STUMBLED OR FALLEN BECAUSE OF DIZZINESS?	YES	NO
9. DID YOU EVER INJURE YOUR HEAD?	YES	NO
10. DO YOU TAKE ANY MEDICATION REGULARLY? (I.E., TRANQUILIZERS, ORAL CONTRACEPTIVES, BARBITURATES, ANTIBIOTICS SUCH AS STREPTOMYCIN, NEOMYCIN OR ANY OVER THE COUNTER MEDICATIONS)	YES	NO
11. HAVE YOU EVER HAD ANY IV ANTIBIOTICS IN THE HOSPITAL?	YES	NO
12. HAVE YOU WORKED FOR LONG IN A NOISY ENVIRONMENT?	YES	NO
13. DO YOU SUFFER EASILY FROM MOTION SICKNESS?	YES	NO

III. CHECK THE APPROPRIATE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING:

	RIGHT EAR	LEFT EAR
1. DIFFICULTY IN HEARING?		
2. CHANGE IN HEARING WHEN DIZZY?		
3. DISTORTION OF HEARING?		
4. NOISE OR RINGING IN EARS?		
5. FULLNESS OR PRESSURE IN EARS?		
6. PAIN IN YOUR EARS?		
7. DRAINAGE FROM YOUR EAR?		

IV. PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. BLURRED OR DOUBLE VISION IN ASSOCIATION WITH DIZZINESS?	YES	NO
2. DID YOU RECENTLY CHANGE EYEGLASSES?	YES	NO
3. NUMBNESS IN HANDS OR FEET?	YES	NO
4. WEAKNESS IN ARMS OR LEGS?	YES	NO
5. TINGLING IN THE MOUTH OR FACE?	YES	NO
6. DIFFICULTY SPEAKING?	YES	NO
7. LOSS OF CONSCIOUSNESS OR BLACKOUTS?	YES	NO
8. DURING THE DIZZY SPELLS DO YOU:		
a. HAVE A DIMMING OR FADING OUT OF VISION?	YES	NO
b. BREAK OUT IN A COLD SWEAT?	YES	NO
9. CAN YOU RELATE YOUR DIZZINESS TO COUGHING, URINATION OR DEFACATION?	YES	NO
10. DO YOU HAVE NEUROLOGICAL PROBLEMS (SUCH AS MULTIPLE SCLEROSIS)?	YES	NO
11. HAVE YOU EVER HAD A STROKE?	YES	NO
12. DO YOU HAVE ANY HEART PROBLEMS SUCH AS IRREGULAR HEART BEAT, CONGESTIVE HEART FAILURE OR ANGINA (CHEST PAIN)?	YES	NO
13. DO YOU HAVE DIABETES?	YES	NO
14. DO YOU HAVE ANY THYROID PROBLEMS?	YES	NO
15. HAVE YOU EVER HAD SYPHILIS?	YES	NO
16. DO YOU HAVE EPILEPSY?	YES	NO
17. IS THERE ADDED STRESS IN YOUR LIFE RECENTLY?	YES	NO
18. HAVE YOU EVER HAD A CT SCAN OF THE HEAD?	YES	NO
19. DO YOU HAVE HIGH BLOOD PRESSURE?	YES	NO
20. DO YOU HAVE HIGH CHOLESTEROL?	YES	NO
21. DO YOU HAVE MIGRAINES?	YES	NO

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