

- YES NO 12. Were you exposed to any irritating fumes, paints, etc. at the onset of your symptoms?
- YES NO 13. If you ever injured your head, were you unconscious?
- YES NO 14. Does your voice echo in your ears?
- YES NO 15. Do you hear your footsteps?
- YES NO 16. Do you hear your eyeballs move?
- YES NO 17. Do you find hair brushing or showering too loud?
- YES NO 18. Do sounds seem too loud?
- YES NO 19. Do loud sounds cause vertigo?
- YES NO 20. Does nose blowing/sneezing/coughing bring on vertigo?
- YES NO 21. Does heavy lifting or straining cause vertigo?
- YES NO 22. Does exercise/physical exertion bring on dizziness?
- YES NO 23. Do you hear ear noises timed with your heartbeat?

SECTION 3: Do you have any of the following symptoms: Please tic **YES** or **NO** and circle ear involved.

- YES NO 1. Difficulty hearing? Both Right Left
- YES NO 2. Noise in your ears? Both Right Left

Describe the noise _____

- YES NO Does the noise change with dizziness? If so, how?

- YES NO 3. Fullness or pressure in your ears? Both Right Left
- YES NO 4. Pain in your ears? Both Right Left
- YES NO 5. Discharge from your ears? Both Right Left
- YES NO 6. Do you use hearing aid? Both Right Left

SECTION 4: LIFE STYLE

- How much do you smoke per day? _____
- How much salt do you use on your food? _____
- How much alcohol do you drink per week? _____
- YES NO Do you commonly eat chocolate?
- YES NO Do you eat much food with MSG?
- YES NO Do you eat much aged cheese?
- What sort of work do you do (or used to do)? _____
- How often do you fly on airplanes? _____
- YES NO Are you presently in litigation or planning litigation about symptoms related to your visit?
- YES NO Are you disabled due to your condition?
- (Women of childbearing age only) are you:**
- YES NO Pregnant
- YES NO Perimenopausal

SECTION 5: Have you experienced any of the following symptoms? Please tic **YES** or **NO** and tic if constant or in episodes

- YES NO 1. Double vision, blurred vision or blindness? Constant Episodes
- YES NO 2. Numbness of face? Constant Episodes
- YES NO 3. Numbness of arms or legs? Constant Episodes
- YES NO 4. Weakness in arms or legs? Constant Episodes
- YES NO 5. Clumsiness of arms or legs? Constant Episodes
- YES NO 6. Confusion or loss of consciousness? Constant Episodes
- YES NO 7. Difficulty with speech? Constant Episodes
- YES NO 8. Difficulty with swallowing? Constant Episodes
- YES NO 9. Pain in the neck or shoulder? Constant Episodes