

Otoneurological Survey

All your answers are confidential and has the same protection as the case record has. It is important for research that you try to answer to all questions with care.

Personal Data

1. **Social security number:**

2. **Name:**

3. **Address:**

4. **Phone number:**

5. **Sex:**

Female

Male

Please mark the answer that best describes your health.

Answer to the questions concerning symptoms in a way that best describe the usual occurrence of them. If you don't have these particular symptoms nowadays, please answer the questions based on the situation when you previously had the symptoms.

6. **What symptoms do you have? (choose one or more options)**

vertigo

moving difficulties

hearing loss

tinnitus

headache

Beginning of the Symptoms

7. **If you have or have previously had vertigo, hearing loss or tinnitus, with which symptoms did your disease start? (choose one or more options)**

vertigo

hearing loss

tinnitus

pressure feeling in the
ear

moving difficulties

8. **How old were you when the symptoms began?**

If you don't have vertigo, please move on to question 21.

9. If you have or have previously had vertigo and hearing loss, was there time difference between the attack of vertigo and hearing loss? (choose only one option)

1 = started at the same
time

2 = less than year

3 = 1 - 4 years

4 = 5 - 10 years

5 = more than 10 years

Vertigo

With vertigo episodes we mean temporary feeling of vertigo with few or no symptoms between the attacks.

With constant vertigo is meant continuous moving difficulties or ongoing feeling of vertigo.

10. Do you have these symptoms? (choose one or several options)

feeling of rotation

feeling of floating

tendency to fall

instability when moving

blackouts

11. When did the first vertigo symptoms occur? (choose one option)

1 = less than month
ago

2 = less than year ago

3 = 1 - 4 years ago

4 = 5 - 10 years ago

5 = more than 10 years
ago

12. What kind of vertigo do you have?

1 = constant

2 = episodes

3 = both

If you have constant vertigo, please move on to the question 18.

13. How often do stronger episodes of vertigo occur?

1 = less than once a
year

2 = less than once a
month

3 = monthly

4 = weekly

5 = daily

14. If you have vertigo attacks, how long do the stronger vertigo attacks last?

1 = less than 1 minute

2 = 1 - 10 minutes

3 = 20 minutes - 4 hours

4 = 4 hours - 24 hours

5 = more than day

15. How severe are the vertigo attacks usually?

1 = mild (doesn't affect
chores at all)

2 = weak (affects but
can continue working
normally)

3 = moderate (have to
stop working)

4 = strong (must rest)

5 = very strong
(difficulties despite rest)

16. Do your vertigo attacks include nausea and/or vomiting?

0 = no

1 = weak

2 = moderate

3 = strong

4 = very strong vomiting

17. Do you have sudden and strong drop attacks or falls lasting a second or two?

0 = no

1 = rarely

2 = less than once a
week

3 = weekly

4 = daily

18. Do changes in position induce vertigo?

0 = no

1 = weakly

2 = moderately

3 = strongly

4 = very strongly (falls)

19. Do change in pressure (eg. flying, diving, blowing or sneezing) induce vertigo or balance difficulties?

0 = no

1 = weakly

2 = moderately

3 = strongly

4 = very strongly (falls)

20. Does physical strain (eg. weight lifting) induce vertigo or balance difficulties?

0 = no

1 = weakly

2 = moderately

3 = strongly

4 = very strongly (falls)

Mobility

21. Do you have balance or moving difficulties between attacks of vertigo?

0 = no

1 = rarely

2 = less than once a
week

3 = weekly

4 = constantly

22. If you have constant unsteadiness between attacks of vertigo, how severe is this?

0 = no handicap

1 = weak

2 = moderate

3 = severe

4 = very severe (falls)

23. Moving

0 = I can move normally

1 = I can move normally
with little difficulty2 = I can move with
marked difficulty3 = I can move only a
little

4 = I am unable to move

24. Standing up from the chair0 = normally without
using your hands1 = with occasional help
for your hands

2 = with your hands

3 = with help from
others

4 = I can't get up

Hearing Loss

25. Has your hearing deteriorated?

0 = no

1 = in right ear

2 = in left ear

3 = in both ears

If you don't have hearing loss, please move on to question 29.

26. If you feel that your hearing has deteriorated, how much time has passed from the beginning of your hearing loss?

1 = less than month

2 = less than year

3 = 1 - 4 years

4 = 5 - 10 years

5 = more than 10 years

27. Does your hearing fluctuate during the vertigo attacks?

0 = no

1 = yes

28. How did your hearing loss start?

1 = suddenly (in few days)

2 = over a few months

3 = over several years

Tinnitus and Hyperacusis

With tinnitus is meant different sounds (eg. ringing, hum, feeling of pulse etc.) occurring in the ear or head, ie. tinnitus.

Hyperacusis refers to discomfort in the ear caused by strong voices or sensing voices very loud.

29. Which ear has the noise?

0 = no tinnitus

1 = right ear

2 = left ear

3 = bilateral

4 = noise is in whole head

If you don't have tinnitus, please move on to question 33.

30. When did your tinnitus first occur?

1 = less than month ago

2 = less than a year ago

3 = 1 - 4 years ago

4 = 5 - 10 years ago

5 = more than 10 years ago

31. How much handicap does tinnitus cause in your life?

0 = no handicap (doesn't affect chores)

1 = slight handicap (no real effect on normal life)

2 = moderate handicap (some disturbance on normal life)

3 = severe handicap (affects concentration and/or sleep)

4 = very severe handicap (completely disrupts my life)

32. What type of tinnitus do you have?

1 = hum

2 = ring

3 = pulse

4 = buzz, hiss, stir

5 = other, several

33. Do strong voices hurt you (hyperacusis)?

0 = no

1 = in the right ear

2 = in the left ear

3 = in both ears

34. Handicap of hyperacusis

0 = no handicap

1 = mild

2 = moderate

3 = severe

4 = very severe

35. Do you have a pressure feeling in the ear?

0 = no

1 = in the right ear

2 = in the left ear

3 = in both ears

Other Symptoms

36. Do you have other symptoms? (choose one or several options)

no other symptoms

feeling of faintness

feeling of drunkenness

blurring of eyes, growing black

feeling of unreality

37. Handicap of other symptoms (choose one alternative)

0 = no handicap

1 = mild

2 = moderate

3 = severe

4 = very severe

38. Anxiety or nervousness (Does vertigo, hearing loss or tinnitus cause these symptoms?)

0 = no

1 = slightly

2 = moderately

3 = severely

4 = very strongly

39. Energetic

0 = I feel healthy

1 = I'm a little exhausted

2 = I feel fairly moderately tired

3 = I feel exhausted

4 = I feel totally exhausted

Headache

If you have episodes of vertigo, please answer to next questions based on the headache outside the spells.

40. How long does headache last?

0 = no headache

1 = less than 2 hours

2 = 2 hours - 24 hours

3 = constant headache

If you don't have headaches outside attacks, please move on to question 43.

41. How often does the headache occur?

1 = less than once a year

2 = less than once a month

3 = monthly

4 = weekly

5 = daily

42. Do you have headaches during the vertigo attacks?

0 = no

1 = rarely

2 = moderately

3 = frequently

4 = very frequently

Neurological Symptoms**Do you have or suffer from next symptoms?**

0 = No

1 = Yes

a) Tend to faint (unconsciousness)

b) Blurring of your vision or double vision during attacks of vertigo

c) Weakness of your voice, stuttering or blurring of your speech (dysarthria) during attacks of vertigo

d) Difficulties in swallowing (cranial nerve palsy)

e) Fingling in your face or disturbance of sensitivity

f) Migraine which has been diagnosed by a physician

Alcohol**44. How many restaurant-sized measures of alcohol do you consume in a week?**

0 = I don't use alcohol

1 = less than 4 units

2 = 5 - 9 units

3 = 10 - 20 units

4 = more than 20 units

Oto- and Vestibulotoxic Drugs**Do you use or have had drugs for these?**

0 = No

1 = Yes

a) Heart medicines (diuretics)

b) Antibiotics by injection (apart from Penicillin)

46. Do you use strong pain killers eg. Burana?

0 = no

1 = occasionally

2 = weekly

3 = daily

Do you use or have had drugs for these?

0 = No

1 = Yes

c) Treatment for malignant tumours/cancers

d) Tablets for depression

e) Other psychotropic drugs

f) Sleeping pills

Possible Damages of Internal Ear

Have you had any...

	0 = No	1 = Yes
a) Direct injury to the head or neck which was associated with the beginning of vertigo symptoms? (symptoms occurred in 6 months of the event)	<input type="checkbox"/>	<input type="checkbox"/>
b) Concussion with unconsciousness lasting less than 2 hours in which year?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
c) Brain injury with unconsciousness lasting more than 2 hours in which year?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
d) Whiplash injury in which year?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
e) An ear infection or prolonged (over three months) ear discharge / running ear caused by inflammation	<input type="checkbox"/>	<input type="checkbox"/>
f) Direct injury of the ear, acute noise injury, bleeding from the ear which would have caused hearing loss or tinnitus in which year?	<input type="checkbox"/>	<input type="checkbox"/>
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g) Been exposed to loud noise at work (noise level exceeding 85 dB) for more than 5 years	<input type="checkbox"/>	<input type="checkbox"/>

Ear Operations

49. Have you had a ear operation?

0 = no	1 = I don't know	2 = yes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you haven't had a ear operation, please move on to question 67.

50. Which ear was operated on?

1 = right ear	2 = left ear	3 = both ears	4 = I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you know what has been operated on, please answer to following questions. If you don't know, please move on to question 67.

51. Have you had ear surgery because of vertigo?

0 = no

1 = yes,

what?

in which year?

Other Diseases

Do you have these diseases?

	0 = No	1 = Yes
a) Any symptoms of coronary heart disease	<input type="checkbox"/>	<input type="checkbox"/>
b) Hypertension/ high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
c) Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>
d) Any symptoms of brainstem ischemia	<input type="checkbox"/>	<input type="checkbox"/>
e) Kidney insufficiency/renal failure	<input type="checkbox"/>	<input type="checkbox"/>
f) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
g) Thyroid gland over- or underproduction	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you suffered from meningitis or sequelae of mumps? what?	<input type="checkbox"/>	<input type="checkbox"/>
in which year?		

Family History

53. Does/did your father or mother have vertigo or hearing loss before the age of 65?

0 = no <input type="checkbox"/>	1 = I don't know <input type="checkbox"/>	2 = yes <input type="checkbox"/>
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54. Do any of your siblings have vertigo or hearing loss before the age of 65?

0 = no <input type="checkbox"/>	1 = I don't know <input type="checkbox"/>	2 = yes <input type="checkbox"/>
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55. Do your children have hearing loss?

0 = no <input type="checkbox"/>	1 = I don't know <input type="checkbox"/>	2 = yes <input type="checkbox"/>
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56. If yes for something above, do you know the reason for the vertigo or hearing loss in your family?

1 = I don't know	<input type="checkbox"/>
2 = yes,	<input type="checkbox"/>
what?	

57. How many siblings do you have?

0 = none <input type="checkbox"/>	1 = one <input type="checkbox"/>	2 = two <input type="checkbox"/>	3 = three <input type="checkbox"/>	4 = more than three <input type="checkbox"/>
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ENRICHED QUALITY OF LIFE QUESTIONNAIRE (EQ-5D)

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- I have no problems in walking about.....
- I have some problems in walking about.....
- I am confined to bed.....

Self-Care

- I have no problems with self-care
- I have some problems washing and dressing myself.....
- I am unable to wash or dress myself

Usual activities *(e.g. work, study, housework, family or leisure activities)*

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform usual activities

Pain/Distress

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

- I am not anxious or depressed
- I am moderately anxious or depressed.....
- I am extremely anxious or depressed

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