







Weather		Medications/Supplements																																									
_____ °F - _____ °F Barometric Pressure: _____ Pollen Count: _____	Check one: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="radio"/></div> <div style="text-align: center;"> <input type="radio"/></div> <div style="text-align: center;"> <input type="radio"/></div> </div> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 10px;"> <div style="text-align: center;"> <input type="radio"/></div> <div style="text-align: center;"> <input type="radio"/></div> <div style="text-align: center;"> <input type="radio"/></div> </div>	List all: _____ _____ _____ _____ _____																																									
Sleep		Vertigo Attacks																																									
Time Awake: _____ Time to Bed: _____ Quality of Sleep: _____ <div style="display: flex; justify-content: center; align-items: center; gap: 5px;"> 1 2 3 4 5 6 7 8 9 10 <small>Bad</small> <small>Great</small> </div>		Did you have an attack: <input type="radio"/> Yes <input type="radio"/> No Duration: _____ Intensity (1-10): _____ Notes: _____ _____																																									
Diet		Exercise																																									
Breakfast: _____ Total Sodium: _____ Total Sugar: _____		Notes: _____ _____																																									
Lunch: _____ Total Sodium: _____ Total Sugar: _____		Type: _____ Duration: _____ Notes: _____ _____																																									
Dinner: _____ Total Sodium: _____ Total Sugar: _____		Daily Check In <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="width: 70%;"></th> <th style="width: 10%;">Morning</th> <th style="width: 10%;">Afternoon</th> <th style="width: 10%;">Night</th> </tr> </thead> <tbody> <tr><td>Vertigo (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Dizziness (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Tinnitus (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Aural Fullness (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Brain Fog (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Headache (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Hearing Loss (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Nausea (1-10)</td><td></td><td></td><td></td></tr> <tr><td>Sensory Overload (1-10)</td><td></td><td></td><td></td></tr> </tbody> </table>			Morning	Afternoon	Night	Vertigo (1-10)				Dizziness (1-10)				Tinnitus (1-10)				Aural Fullness (1-10)				Brain Fog (1-10)				Headache (1-10)				Hearing Loss (1-10)				Nausea (1-10)				Sensory Overload (1-10)			
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Caffeine? _____ Alcohol? _____ Tobacco? _____		Stress Did you meditate: <input type="radio"/> Yes <input type="radio"/> No How long: _____ Stress Level: _____ <div style="display: flex; justify-content: center; align-items: center; gap: 5px;"> 1 2 3 4 5 6 7 8 9 10 <small>min</small> <small>Max</small> </div> Notes: _____ _____ _____																																									