Resize font:

Motion Sickness Questionnaire

Hi there! Thank you for taking the time to fill out our survey. We are a UCI research team investigating the heritability of motion sickness. Please fill the short survey below to help us gather information about you and your family's experience with motion sickness. It will take 15 minutes to complete and you will be eligible to win a $35 Amazon gift card! Chances of winning are no less than 1 in 33 people.

What is your email? This will be used for raffle prize giveaway, your email will be recorded separate from the rest of the survey so your answers will stay anonymous.

1. Please state your age.

2. What is your gender?

- Male
- Female

reset

3. What is your current occupation?

4. Do you regard yourself as susceptible to motion sickness?

- Not at all
- Slightly
- Moderately
- Very much so

reset

Section A: Your CHILDHOOD Experience
5. For each of the following types of transport or entertainment please indicate:
As a child (before age 12), how often you Travelled or experienced:

Cars

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Busses or Coaches

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Trains

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Aircraft

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Small boats

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Ships e.g. Channel Ferries

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Swings

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Roundabouts: playgrounds

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Funfair Rides, Big Dippers

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Section A: Your CHILDHOOD Experience
For each of the following types of transport or entertainment please indicate:
6. As a child (before age 12), how often you felt sick or nauseated in:

Cars

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Busses or Coaches

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Trains

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Aircraft

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Small boats

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Ships e.g. Channel Ferries

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Swings

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Roundabouts: Playgrounds

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Funfair Rides, Big Dippers

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Section A: Your CHILDHOOD Experience
For each of the following types of transport or entertainment please indicate:
7. As a child (before age 12), how often you vomited in:

Cars

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Busses or Coaches

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Trains

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Aircrafts

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Small Boats

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Ships e.g. Channel Ferries

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Swings

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Roundabouts: playgrounds

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Funfair Rides, Big Dippers

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Section B: Your Experience Over the Last 10 years.
For each of the following types of transport or entertainment please indicate:
8. Over the Last 10 years (approximately), how often you Travelled or experienced (tick boxes):

Cars

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Busses or Coaches

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Trains

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Aircrafts

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Small boats

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Ships e.g. Channel Ferries

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Swings

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Roundabouts: playgrounds

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Funfair Rides, Big Dippers

- Never
- 1 to 4 trips
- 5 to 10 trips
- 11+ trips

reset

Section B: Your Experience Over the Last 10 years.
For each of the following types of transport or entertainment please indicate:
9. Over the Last 10 years (approximately), how often you felt sick or nauseated in:

Cars

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Busses or Coaches

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Trains

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Aircraft

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Small Boats

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Ships e.g. Channel Ferries

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Swings

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Roundabouts: playgrounds

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Funfair Rides, Big Dippers

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Section B: Your Experience Over the Last 10 years.
For each of the following types of transport or entertainment please indicate:
10. Over the Last 10 years (approximately), how often you vomited in:

Cars

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Busses or Coaches

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Trains

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Aircraft

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Small Boats

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Ships e.g. Channel Ferries

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Swings

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Roundabouts: playgrounds

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

Funfair Rides, Big Dippers

- Never
- Rarely
- Sometimes
- Frequently
- Always

reset

11. Does your Mother experience motion sickness?

- Yes
- No
- Unknown

reset

12. Does your Father experience motion sickness?

- Yes
- No
- Unknown

reset

13. Does your Grandmother experience motion sickness?

- Yes
- No
- Unknown

reset

14. Does your Grandfather experience motion sickness?

- Yes
- No
- Unknown

reset

15a. How many brothers do you have?

15a. How many of your brothers experience motion sickness?

15b. How many sisters do you have?

15b. How many of your sisters experience motion sickness?

Dizziness Questionnaire

1. Do you experience dizziness? (If no, skip to question # 9)

- ○ No
- ○ Yes

reset

2. When did you experience your first episode of dizziness? Please write the approximate month and year.

4. How often do you experience dizziness? ___ times per: Fill the blank in the next question

- ○ day
- ○ week
- ○ month
- ○ year

reset

4. How often do you experience dizziness? ___ times per (what you chose in the previous questions).

4. What triggered your dizziness?

5. Choose the most accurate description of your dizziness

- ○ Room Spinning
- ○ Feels like you are on a boat
- ○ Lightheaded
- ○ Imbalance
- ○ Problems focusing with
- ○ head movement

reset

5. Choose the 2nd most accurate description of your dizziness

- ○ Room Spinning
- ○ Feels like you are on a boat
- ○ Lightheaded
- ○ Imbalance
- ○ Problems focusing with
- ○ head movement

reset

5. Choose the 3rd most accurate description of your dizziness

- ○ Room Spinning
- ○ Feels like you are on a boat
- ○ Lightheaded
- ○ Imbalance
- ○ Problems focusing with
- ○ head movement

reset

5. Choose the 4th most accurate description of your dizziness

- Room Spinning
- Feels like you are on a boat
- Lightheaded
- Imbalance
- Problems focusing with
- head movement

reset

Choose the 5th most accurate description of your dizziness.

- Room Spinning
- Feels like you are on a boat
- Lightheaded
- Imbalance
- Problems focusing with
- head movement

reset

How long do your episodes of dizziness typically last?

- Seconds
- Minutes
- Hours
- Days
- Weeks

reset

Be specific about the previous questions with a numeric number. For example, if your episodes last 10 seconds, choose seconds in the previous question and write 10 here.

7. Did your dizziness start after head trauma or brain surgery?

- Yes
- No

reset

8. Do you have dizziness when you look up?

- Yes
- No

reset

9. Do you experience motion sickness?

- Yes
- No

reset

9a. Did you ever experience motion sickness as a passenger in a car including childhood?

- Yes
- No

reset

9b. Do you experience dizziness or headaches when watching 3-D movies?

- Yes
- No

reset

10. Have you ever experienced head/ brain fog (i.e. feelings of mental confusion or lack of mental clarity)?

- Yes
- No

reset

11. Do you experience dizziness with headaches?

- ○ Always
- ○ Sometimes
- ○ Never

reset

12. Have you suffered from headaches in the past year?

- ○ Yes
- ○ No

reset

13. When did you experience your first headache episode? Please write an approximate month and year.

14. How often do you experience headaches? X times per:

- ○ day
- ○ week
- ○ month
- ○ year

reset

14. Please estimate the amount of X in the previous question:

15. How long do your headaches typically last? ____:

- ○ seconds
- ○ minutes
- ○ hours
- ○ days
- ○ weeks

reset

15. Please fill in the blank in the previous question. For example, if you have 10 minute headaches, write 10 here and choose headaches in the previous question.

16. How would you describe the pain of the headaches?

- ○ mild
- ○ moderate
- ○ severe

reset

17. Did your headache start after head trauma or brain surgery?

- ○ Yes
- ○ No

reset

18. Do your headaches get worse with Menstrual periods?

- ○ Yes
- ○ No
- ○ Not applicable

reset

18. Do your headaches get worse with birth control?

- ○ No
- ○ Yes
- ○ not applicable

reset

18. Do your headaches get worse with certain food?
- ○ Yes
- ○ No

reset

18. Do your headaches get worse with sleep disturbances?
- ○ Yes
- ○ No

reset

18. Do your headaches get worse with physical activity?
- ○ Yes
- ○ No

reset

18. Do your headaches get worse with Bowel movements (e.g. diarrhea or constipation)
- ○ Yes
- ○ No

reset

19. Where is the headache located? (check all that apply):
- ☐ Right side
- ☐ Left side
- ☐ Forehead
- ☐ Temple
- ☐ Back

20. Have you experienced neck stiffness?
- ○ Yes
- ○ No

reset

21. Do you experience ear pain? If so where.
- ○ Right
- ○ Left
- ○ Both
- ○ No

reset

22. Have you ever experienced recurrent sinus headaches?
- ○ Yes
- ○ No

reset

23. Have you ever experienced ice cream headaches (i.e. brain-freeze)?
- ○ Yes
- ○ No

reset

24. Has wind or air conditioning ever caused you sinus pain, facial pressure, or headache?
- ○ Yes
- ○ No

reset

25. Do you find relief of your headaches with medications?
- ○ Yes
- ○ No

reset

26. Do your headaches reduce your productivity at work or school?
- ○ Yes
- ○ No

reset

27. Do your headaches interfere with your daily life activities (e.g. chores at home)?

- ○ Yes
- ○ No

reset

28. Have you ever been prescribed medication for migraine?

- ○ Yes
- ○ No

reset

29. Do you experience Pulsating or throbbing pain before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience Visual loss, black spots or flashing lights lasting at least 15 min before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience weakness before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience difficulty speaking before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience nausea before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience vomiting before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience sensitivity to light before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience Sensitivity to sounds before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience Drowsiness before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience Unsteadiness before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience lightheadedness before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you Feel like you are on a boat before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

29. Do you experience feeling "off" before/during/after your headaches? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

30. Do you ever experience pain with light touch on your scalp or face?

- ○ Yes
- ○ No

reset

31. Have you ever had your balance system tested? (ie. ENG, VNG, etc.)

- ○ Yes
- ○ No

reset

32. Have you ever been told that you have:

- ☐ Migraines
- ☐ Irritable Bowel Syndrome□□
- ☐ Meniere's Disease
- ☐ Benign positional vertigo□□
- ☐ Gluten Hypersensitivity
- ☐ Celiac Disease□

33. Does anyone in your immediate family have a history of:

- ☐ Migraines
- ☐ Meniere's Disease
- ☐ Motion Sickness

34. Do you have dizziness when you are: check all that apply.

- ☐ Lying down
- ☐ Sitting up
- ☐ Standing up
- ☐ Turning your head
- ☐ Walking
- ☐ Hearing loud noises
- ☐ In a car or moving vehicle
- ☐ Walking in a supermarket aisle
- ☐ Motion
- ☐ Medication
- ☐ Not applicable

35. Are you sensitive to any of the following? (check all that apply):

- ☐ Lights
- ☐ Weather changes
- ☐ Smells
- ☐ Excess motion on TV or computer
- ☐ Excess motion in a movie theater
- ☐ Sounds
- ☐ Not applicable

36.Do you experience Sensation of objects moving around you before, during, or after your dizziness episodes? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not appicable

36.Do you experience Spinning sensation when stationary before, during, or after your dizziness episodes? Check all that apply

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

36.Do you experience Ear pressure or fullness (not relieved by popping your ears) before, during, or after your dizziness episodes? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

36.Do you experience Ringing or buzzing in your ears before, during, or after your dizziness episodes? Check all that apply.

- ☐ Before
- ☐ During
- ☐ After
- ☐ Not applicable

36.Do you experience Pulsing sound in your ears before, during, or after your dizziness episodes? Check all that apply.

- [ ] Before
- [ ] During
- [ ] After
- [ ] Not applicable

36.Do you experience Hearing loss before, during, or after your dizziness episodes? Check all that apply.

- [ ] Before
- [ ] During
- [ ] After
- [ ] Not applicable

36.Do you experience Nausea/ Vomiting before, during, or after your dizziness episodes? Check all that apply.

- [ ] Before
- [ ] During
- [ ] After
- [ ] Not applicable

36.Do you experience Fatigue before, during, or after your dizziness episodes? Check all that apply.

- [ ] Before
- [ ] During
- [ ] After
- [ ] Not applicable

36.Do you experience Unsteadiness/ Imbalance before, during, or after your dizziness episodes? Check all that apply.

- [ ] Before
- [ ] During
- [ ] After
- [ ] Not applicable

36.Do you experience Headache before, during, or after your dizziness episodes? Check all that apply.

- [ ] Before
- [ ] During
- [ ] After
- [ ] Not applicable

36.Do you experience Anxiety before, during, or after your dizziness episodes? Check all that apply.

- [ ] Before
- [ ] During
- [ ] After
- [ ] Not applicable

37. If you experienced any of the above symptoms, how long did they last?

- ( ) Minutes
- ( ) Hours
- ( ) Days
- ( ) Weeks
- ( ) Not applicable

reset

Submit