Beach
Audiology

BALANCE ASSESSMENT Pre-Testing Instructions

Comprehensive balance testing has been recommended and scheduled for you. The test is scheduled for approximately 90 minutes..
Testing is performed to evaluate the function of the inner ear and central motor function. During the testing, your inner ear and central motor balance system will be stimulated by sound and watching moving lights, with different head and body positions, and by circulating cool and warm air into your ear canals. Lightweight goggles with small infrared cameras will be worn to measure and record your eye movements during the testing. Patients may experience some sensation of movement during various portions of the test. Most patients report the potential dizziness experienced during the testing as mild compared to their symptomatic dizziness.

Discontinue use of the following medications for 24 hours prior to your test (these substances can influence the body's response to this test and give false responses):

- Antibiotics: Streptomycin, Gentamicin.
- Anti-depressants: including Elavil, Pamelor, Prozac, Lithium, etc.
- Anti-histamine medications: including Chlor Trimeton, Dimetane, Benadryl, Disophrol, Actifed, Allegra, Claritin, Seldane, Triaminic, or any over-the-counter cold remedies, etc.
- Anti-nausea medications: including Dramamine, Compazine, Vontrol, Phenergan, Thorazine, Transderm (scopolamine patch worn behind the ear) etc.
- Anti-vertigo medications: including AntiVert, Meclizine, Scopolamine, etc.
- Narcotics and Barbiturates: including Phenobarbital, Codeine, Demerol, Dilaudid, Percodan, Phenaphen, Seconal, Chloral hydrate, etc.
- Sedatives: including Nembutal, Seconal, Dalmane, Placidyl, Butisol, or any other sleeping pills.
- Stimulants: including Ritalin, Methylphenidate, Amphetamine, etc.
- Tranquilizers: including Valium, Librium, Atarax, Vistaril, Equanil, Miltown, Triavil, Serax, Etrafon, Xanax, Ativan, Sarafem, etc.

Additional instructions:

- Avoid wearing make-up, **especially eye make-up.**
- Do not wear contact lenses, but do bring eye glasses if needed.
- Dress comfortably, as you will be sitting and lying on an exam table for the duration of testing.
- Avoid solid foods 2 to 4 hours before the test.
- Avoid caffeine (coffee, tea, cola) after midnight prior to testing.
- Avoid alcoholic beverages (and liquid medicine containing alcohol) 48 hours before the test.
- Discontinue all medication 48 hours prior to the test except "maintenance" medication for your heart, blood pressure, diabetes, or seizures, and any medications deemed by your physician to be necessary.
- Because this test may cause you to feel dizzy, we recommend that you have someone drive you to your appointment.

Failure to comply with these instructions may result in your appointment being rescheduled for a later date.

Beach Audiology

COMPREHENSIVE BALANCE ASSESSMENT -- PRE-VISIT INSTRUCTIONS

Name: _____

VNG Appointment Date &Time: _____

☐ COMPREHENSIVE BALANCE ASSESSMENT ☐ OTHER _____

We will file with you insurance company for payment of this test on your behalf. Please be aware that you will be responsible for any co-pay or deductible that you may have with your insurance company.

It is very important for you to read the attached directions very carefully as soon as possible. Please complete the attached questionnaire and bring it with you on the day of your appointment.

The test will take approximately 90 minutes to complete, so please be on time for your appointment.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure recommended so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to alarm you, it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I (we) voluntarily request the providers of BEACH AUDIOLOGY HEARING & BALANCE CENTER to treat my condition which has been explained to me.

I (we) understand the following diagnostic procedures are planned for me and I (we) voluntarily consent and authorize the following procedure: **COMPREHENSIVE BALANCE ASSESSMENT**

I (we) understand that no warranty or guarantee has been made to me a result of care.

I certify this form has been fully explained to me and that I have read it or have had it read to me. I understand its contents. I certify that I have been given both the Case History Questionnaire.

_____

Signature of Patient or other legally responsible person Date

_____

Witness to Signature Date

Patient Name: _____ Date of Birth: ____/____/____

Provider Name: _____ Appointment Date: ____/____/____

Last 4 Digits Social Security # ___ ___ ___ ___ Sex: Male / Female

---

CURRENT SYMPTOMS

Circle One: Are your symptoms **Dizziness** / **Imbalance** / **Both**

Which of the following bests describes your symptoms?

- ☐ Imbalance
- ☐ Falling more often
- ☐ World spinning around you
- ☐ You feel as if YOU are spinning; the room is not spinning
- ☐ Nausea
- ☐ Lightheadedness
- ☐ Other: _____

When did your symptoms begin? ____/_____/_____ (estimate if needed)

How long do your symptoms last without stopping?

- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Symptoms are constant

Did any of the following occur before your symptoms began?

- ☐ Head trauma
- ☐ Motor Vehicle Accident
- ☐ Upper Respiratory Infection
- ☐ Change in medication
- ☐ A virus or infection, e.g., Shingles, Cold Sores
- ☐ Surgery
- ☐ Stressful event or high stress
- ☐ A fall
- ☐ Other: _____

How many times _____ per **day / week / month / year** *(circle one)* do you have an episode?

Which of the following can provoke, increase, or worsen your dizziness?

- ☐ Laying down
- ☐ Looking up
- ☐ Bending over
- ☐ Standing up from bending over
- ☐ Turning your head right or left while seated or standing
- ☐ Rolling over in bed
- ☐ Standing up from a seated position OR sitting up from a laid position
- ☐ Increased Stress
- ☐ Skipping a meal
- ☐ Not drinking enough water
- ☐ Other: _____

Circle One: Have your symptoms **Improved / Changed / Stayed the Same** since they began?

If Improved or Changed: How so? _____

Does anything make your symptoms better? _____

Which of the following accompany or occur immediately prior to an episode of your symptoms?

- ☐ Headaches
- ☐ Neck Pain
- ☐ Hearing Loss: **right ear, left ear, both ears** *(circle one)*
- ☐ Fullness in your ear(s): **right ear, left ear, both ears** *(circle one)*
- ☐ Ringing in your ear(s): **right ear, left ear, both ears** *(circle one)*
- ☐ Shimmers or Sparkles in your Vision
- ☐ Sensitivity to **light, sound, smell** *(circle all that apply)*

BALANCE & FALL SYMPTOMS

YES / NO: Have you fallen in the past year?

If yes: How many times? _____
If no: Have you experienced "near falls" but you caught yourself? **YES / NO**

YES / NO: Are you afraid of falling?

YES / NO:: Are you veering/leaning while walking? *If yes:* Which direction? **Right**, **Left**, **Both**

YES / NO:: Do you have neuropathy, numbness, or tingling in your feet or legs?

YES / NO:: Has your exercise decreased? *If yes:* Approximately when? ____/____/____

YES / NO:: Orthopedic injuries? *If yes:* Please explain: _____

MEDICAL HISTORY

YES / NO:: Do you have a history of Migraines?

If yes: When was your most recent Migraine? ____/____/_____

YES / NO:: Are you bothered by patterns, screens, or complex visual environments, e.g., supermarkets?

YES / NO:: Are your Blood Sugar, Blood Pressure, and Thyroid Levels well controlled?

YES / NO:: Have you had any recent changes in hearing?

If yes: Which ear? **right ear**, **left ear**, **both ears** *(circle one)*

If yes: When was your last hearing evaluation? ____/____/_____

YES / NO:: I am experiencing ear **Pain** / **Ringing** / **Drainage** / **Fullness** *(circle all that apply)*

If yes: Which ear? **right ear**, **left ear**, **both ears** *(circle one)*

YES / NO:: Do you have any known eye/vision issues?

If yes: Please explain: _____

IF APPLICABLE: FEMALE HORMONAL HISTORY

Circle One: Are you **Pre / Peri / Post** - Menopausal?

YES / NO:: Do you currently get hot flashes?

YES / NO:: Did you have a hysterectomy? *If yes:* When? ____/____/_____

YES / NO:: Have you had any changes to your contraceptives? *If yes:* When? ____/____/_____

YES / NO: Do you have known hormonal imbalance?

YES / NO: *If yes:* Are you being treated for this issue?