Enclosed you will find information about Midwest Dizziness and Balance Institute. This testing has been ordered to further assist your physician in determining the cause of your dizziness and/or balance concerns.

Please review the material and complete all the forms at least 48 HOURS to your appointment. This is essential as there are eating, drinking, and medication restrictions that must be followed in order to complete this testing

If you have any questions, please call our office at (314) 384-8088. We will call you within 72 hours of your appointment with your doctor to schedule all your tests. Please call us only if you do not hear from us within 72 hours.

Date: ________________________________

Time: ________________________________

Our location:
12380 Olive Blvd.
Creve Coeur, MO 63141
(314) 384-8088 (phone)
(636) 238-4388 (fax)

www.midwestdizzyandbalance.com

Please arrive 15 minutes prior to your appointment with **all your forms already completed.**

If you have any questions or need to change your appointment, please call **314-384-8088**

Please note, due to a high demand for our testing, a $150 refundable deposit is required at the time of scheduling your appointment. This fee will be refunded or applied to your overall balance. Failure to cancel your appointment at least 48 hours prior to testing will result in forfeit of this deposit.

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Dizziness/Balance Evaluation Patient Instructions

Now that you have scheduled your appointment for a test of your balance system, there are a few things you should know prior to your appointment.

ABOUT THE APPOINTMENTS:

About the evaluation appointment:
Your Audiologist will ask you questions about your medical history to gain insight on your overall health. Next, a comprehensive set of testing will be performed during the approximately **3.5-hour** appointment to assess your overall ear health and to determine your vestibular function in a static (at rest) and dynamic (while moving) state. Prior to each test, an explanation will be given so that you know what to expect with each test. The tests are simple and painless.

If you drive yourself to the appointment, plan an additional 15 to 30 minutes before you leave the office, as a few of the tests may cause a sensation of motion that may linger. If possible, we encourage you to have someone drive you to and from your appointment. If you have family, friend(s), or a caregiver with you, they will be asked to sit in the waiting room during testing.

For your comfort and convenience:

- Dress comfortably. Women should avoid wearing skirts or dresses as part of the test requires lying down. You may want to bring a jacket or sweater, it generally stays cool in our office.
- Do not wear any makeup (including foundation, mascara, and eyeliner). Some tests will require placing small adhesive electrodes on the face and neck.
- If you wear hard contact lenses, please wear your glasses.
- If you wear hearing aids, please wear them and/or bring them with you to your appointment.

About your results appointment:
After your appointment, each test will be carefully analyzed and reviewed with you at the end of your appointment. A detailed report will also be sent to your referring physician regarding our conclusions and recommendations.

About treatment:
Treatment plans tailored to addressing vestibular impairments often involve in-clinic therapy sessions on a regular basis (twice weekly) over several weeks (average of 7 weeks), so it is important that you are available to participate after your testing is complete in order to make you feel well again.

Medications: Always consult your doctor before discontinuing any prescribed medications.

Certain medications significantly affect the tests. They are listed below. If you have any questions, you will need to check with your prescribing physician before you stop any of these medications. Please do not call our office about medications, as we cannot assist you with medications other physicians have prescribed.

It is recommended that the following vestibular suppressants be weaned prior to the test. Some medications can take a week or more to clear from your system. Vestibular suppressants are drugs that reduce the intensity of vertigo and nystagmus (eye movements) evoked by a vestibular imbalance. These also reduce the associated motion sensitivity and motion sickness. Vestibular suppressants should only be used in acute cases to alleviate the stressful symptoms because prolonged use may generate a chronic vestibular imbalance.

- **Anti-histamines**: Chlor-trimeton, Disophrol, Benadryl, Teldrin, Hismanol, Claritin, Allegra, Zyrtec, nearly all over-the-counter allergy or cold medicines
- **Anticholinergics:** Atropine, Belladonna, Hyoscyamine and Scopolamine
- **Benzodiazepines:** Diazepam (Valium), clonazepam, lorazepam and alprazolam (should not be stopped suddenly because of potential withdrawal symptoms)

Below is a partial list of medications that **should not be taken for 48 hours prior to the test.** Ask your doctor if you have concerns about discontinuing your medications.

- **Alcohol:** beer, wine, liquor, cough medicine
- **Analgesics/Narcotics:** Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet
- **Anti-vertigo:** Antivert, Meclizine, Ru-vert
- **Anti-nausea:** Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopolamine, nearly all motion sickness patches or medications
- **Sedatives:** Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pills
- **Tranquilizers:** Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanax

You should continue taking all blood pressure medications, heart medications, thyroid medications, Tylenol, insulin, and estrogen.

Other limitations:

- NO caffeine (coffee, soda, tea, etc.) for 4 HOURS before the test. Please limit caffeine to no more than 8 ounces the day of testing.
- NO smoking for 4 HOURS before the test
- NO eating or drinking for 4 HOURS before the test

Please contact our office if you have any questions. We are looking forward to your visit.

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Dizziness Questionnaire

Patient Name ______________________________ **Date of Birth** ____________ **Date** _____________

ENT Physician ___________________________ **Primary Care Physician** ________________________

1. **Describe your symptoms:** ____

____

____

____

2. **When did your symptoms begin?** ____

3. **Onset nature:** ☐ Gradual ☐ Sudden

4. **Severity of Symptoms:**

☐ More Frequently ☐ More Severe ☐ Improved ☐ No change ☐ Worse

5. Select all that apply DURING your dizzy spells:

- ☐ Preceded by flu/cold
- ☐ Spinning sensation (vertigo)
- ☐ Swaying/Rocking sensation
- ☐ Falling to the Right side
- ☐ Fall to the Left side
- ☐ Trouble walking in the dark
- ☐ Changes in your hearing
- ☐ Nausea
- ☐ Vomiting
- ☐ Perspiration, shortness of breath, or feeling of panic
- ☐ Lightheadedness or swimming sensation
- ☐ Better if sit or lie still
- ☐ Fullness/pressure in ears
- ☐ Ringing in the ears
- ☐ Stress
- ☐ Menstrual period
- ☐ Hormonal changes
- ☐ Overwork or exertion
- ☐ Headaches/ Migraines
- ☐ Sensitivity to loud noises
- ☐ Sensitivity to light

6. Imbalance when walking? ☐ Yes ☐ No ☐ to the right ☐ to the left

7. Comes in attacks or episodes? ☐ Yes ☐ No

8. How often?

☐ Daily ☐ Multiple times a day ☐ Weekly ☐ Monthly ☐ Multiples times a year ☐ Annually

9. How long do they last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

10. When was the last attack or episode? ____

11. Are you completely free from dizziness between attacks/episodes? ☐ Yes ☐ No

12. Do you have any warning signs prior to an attack/episode? ☐ Yes ☐ No

If yes, please explain:____

____

13. Have you had any head injury or trauma within the last 12 months or around the onset of dizziness symptoms? ☐ Yes ☐ No

If yes, please explain:____

14. Dizziness/Imbalance worsens with or triggered by:

☐ Standing ☐ Laying down in bed

- [ ] Walking
- [ ] Walking in the dark
- [ ] Transferring to standing from sitting or supine position
- [ ] Looking up/down
- [ ] Turning to left or right
- [ ] Bending over
- [ ] Loud sounds
- [ ] Pressure changes
- [ ] Changing positions in bed
- [ ] Stress/Fatigue
- [ ] Visual stimulation
- [ ] Quick head movements
- [ ] Riding in an automobile or elevator
- [ ] Bright lights
- [ ] Straining (coughing, sneezing, lifting heavy objects)
- [ ] Specific food or drink: ________________
- [ ] Other: ________________

15. Is there anything you can do to help alleviate your dizziness? ☐ Yes ☐ No

If yes, please explain:____

16. Other sensations include:

- [ ] Blacking out or fainting when dizzy
- [ ] Dizzy or unsteady constantly
- [ ] Severe or recurrent headaches
- [ ] Double or blurry vision
- [ ] Numbness in the face or extremities
- [ ] Weakness/Clumsiness in arms or legs
- [ ] Slurred or difficult speech
- [ ] Tingling around mouth
- [ ] Spots before eyes
- [ ] Jerking of arms or legs
- [ ] Dizzy when stand up quickly
- [ ] Weakness/Faintness after not eating
- [ ] Difficulty Swallowing
- [ ] Migraine

17. My current symptoms also include (can occur with or without dizziness episode):

- [ ] Difficulty hearing in Right ear
- [ ] Difficulty hearing in Left ear
- [ ] Ringing in Right ear
- [ ] Ringing in Left ear
- [ ] Fullness in Right ear
- [ ] Fullness in Left ear
- [ ] Pain in Right ear
- [ ] Pain in Left ear
- [ ] Discharge in Right ear
- [ ] Discharge in Left ear
- [ ] Hearing change in Right ear
- [ ] Hearing change in Left ear
- [ ] Exposure to loud noise in Right ear
- [ ] Exposure to loud noise in Left ear
- [ ] History of Right ear infection
- [ ] History of Left ear infection

18. Have you ever had previous ear surgery?

☐ Yes ☐ No ☐ Years ago ☐ Months ago Procedure: ________________

19. Have you ever worn or currently wear hearing aids? ☐ Yes ☐ No

20. Medical History also includes:

- [ ] Back or neck surgery Date: ____________
- [ ] Back or neck pain ☐ Recent onset
- [ ] Back or neck injury Date: ____________
- [ ] Seasickness or car sickness ☐ Recent onset
- [ ] Motion intolerance ☐ Recent onset
- [ ] Sensitivity to light and/or sound ☐ Recent onset
- [ ] Not applicable

21. What physicians or specialists have you seen previously <u>FOR YOUR DIZZINESS</u>?

- [ ] Primary Care Physician
- [ ] ENT
- [ ] Cardiologist
- [ ] Neurologist
- [ ] ER or Urgent Care
- [ ] Chiropractor
- [ ] Physical Therapist # of visits ______
- [ ] Other: ________________

22. What tests have been done previously <u>FOR YOUR DIZZINESS</u>?

☐ Hearing Test ☐ MRI ☐ CT scan ☐ Bloodwork ☐ Angiogram ☐ Other: ________________

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Health Questionnaire

Please complete all entries.

Patient Name: ______________________________ **Date of Birth:** ____________________

A. Medication: List all medications that you are taking. Include over-the-counter drugs.

Name	Strength	Frequency	Condition being treated

B. Have there been any recent changes to your medications? (change in dosage or new medication)

☐ Yes ☐ No

If yes, please explain nature and date of change:____

____

C. Allergies to medications: ____

D. Surgical History/Hospitalizations: List all surgeries. If applicable, list the year and the reason for any hospital admissions. Do not include normal pregnancies.

Year	Condition/Illness/Surgery

E. Social History: Please check appropriate box and give amount.

1. Do you smoke? ☐ Yes ☐ No How many packs per day? ☐ less than ½ ☐ ½-1 ☐ 1-3 ☐ 3+
2. Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? ☐ 1 ☐ 2-5 ☐ 6-10 ☐ 11+
3. Do you drink caffeine products? ☐ Yes ☐ No What kind? ☐ tea ☐ coffee ☐ soda

If you drink caffeine products, how many 8 oz cups per day? ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4+

F. Symptom Review: Please select to indicate if you have had any of the following symptoms or diseases:

Constitutional
- ☐ Chronic Fatigue
- ☐ Weight loss
- ☐ Weight gain

Eyes
- ☐ Blurry vision
- ☐ Vision Changes
- ☐ Cataracts
- ☐ Crossed eye
- ☐ Double vision
- ☐ Spots before eyes

ENT
- ☐ Hearing loss
- ☐ Ear aches
- ☐ Ear drainage
- ☐ Ear itching
- ☐ Tinnitus
- ☐ Sneezing & congestion
- ☐ Facial pain
- ☐ Vertigo
- ☐ Breathing difficulty
- ☐ Heartburn
- ☐ Throat pain
- ☐ Difficulty swallowing
- ☐ Facial weakness
- ☐ Sinus trouble

General
- ☐ Cancer Type: ________
- ☐ Currently pregnant
- ☐ Currently breastfeeding
- ☐ Other: ______________

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Swelling in legs
- ☐ Heart attack
- ☐ Any heart trouble
- ☐ High blood pressure
- ☐ Low blood pressure

Musculoskeletal
- ☐ Joint Pain/stiffness
- ☐ Neck Pain
- ☐ Fibromyalgia
- ☐ Significant arthritis

Respiratory
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Tuberculosis

Gastrointestinal
- ☐ Decreased appetite
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Food Intolerance
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hepatitis
- ☐ Kidney disease

Integumentary
- ☐ Rash
- ☐ Jaundice
- ☐ Skin Cancer
- ☐ Eczema
- ☐ Psoriasis

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Migraines
- ☐ Tingling
- ☐ Numbness
- ☐ Blackouts
- ☐ Fainting
- ☐ Tremor/shaky hands
- ☐ Seizures
- ☐ Paralysis
- ☐ Stroke
- ☐ Memory loss
- ☐ Meningitis
- ☐ Peripheral neuropathy
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis

Psychiatric
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal tendencies
- ☐ Nervous breakdown

Endocrine
- ☐ Thyroid trouble
- ☐ Excessive Sweating
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased urinary frequency
- ☐ Hormone therapy
- ☐ Diabetes Type: ____
- ☐ Hypoglycemia

Hematologic
- ☐ Easy Bruising
- ☐ Increased Bleeding
- ☐ Enlarged lymph nodes
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Previous transfusions

Immunologic
- ☐ Hives
- ☐ Hay fever
- ☐ Seasonal allergies
- ☐ Increased infections
- ☐ Food allergies
- ☐ Autoimmune disorder
- ☐ HIV exposure
- ☐ HIV positive
- ☐ Venereal disease
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Scarlet fever

G. Family History: Select the following diseases which are common in your family or have occurred in any family member. Do not include family members by marriage or adoption.

- ☐ asthma
- ☐ auto immune disease
- ☐ bleeding disorder
- ☐ Multiple Sclerosis
- ☐ dizziness
- ☐ diabetes
- ☐ hay fever
- ☐ hearing loss
- ☐ heart disease
- ☐ high blood pressure
- ☐ kidney disease
- ☐ Meniere's disease
- ☐ migraine
- ☐ surgical complications
- ☐ Parkinson's Disease
- ☐ tuberculosis
- ☐ vertigo
- ☐ stroke
- ☐ cancer

H. Medication History: Have you ever taken any of the following drugs? Please select all that apply.

- ☐ Aspirin in large doses
- ☐ Quinidine (for malaria)
- ☐ Cisplatin (for cancer)
- ☐ Streptomycin (antibiotic)
- ☐ Furosemide (Lasix)
- ☐ Tamoxifen (to prevent breast cancer)
- ☐ Gentamicin (antibiotic)
- ☐ Tobramycin (antibiotic)
- ☐ Kanamycin (antibiotic)
- ☐ Vancomycin (antibiotic)
- ☐ Malaria Drugs (quinine)
- ☐ Procardia (for blood pressure)

General/Constitutional

Yes No 1. Have you ever received radiation to the head or neck?

Yes No 2. Do you have untreated diabetes?

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Dizziness Handicap Inventory

Name: ______________________ Date Completed ______________________

1	Does looking up increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No
2	Because of your problem, do you feel frustrated? (E)	☐ Yes	☐ Sometimes	☐ No
3	Because of your problem, do you restrict your travel for business or recreation? (F)	☐ Yes	☐ Sometimes	☐ No
4	Does walking down the aisle of a supermarket increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No
5	Because of your problem, do you have difficulty getting into or out of bed? (F)	☐ Yes	☐ Sometimes	☐ No
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? (F)	☐ Yes	☐ Sometimes	☐ No
7	Because of your problem, do you have difficulty reading? (F)	☐ Yes	☐ Sometimes	☐ No
8	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? (F)	☐ Yes	☐ Sometimes	☐ No
9	Because of your problem, are you afraid to leave your home without having someone accompany you? (E)	☐ Yes	☐ Sometimes	☐ No
10	Because of your problem, have you been embarrassed in front of others? (E)	☐ Yes	☐ Sometimes	☐ No
11	Do quick movements of your head increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No
12	Because of your problem, do you avoid heights? (F)	☐ Yes	☐ Sometimes	☐ No
13	Does turning over in bed increase your problem (P)	☐ Yes	☐ Sometimes	☐ No
14	Because of your problem, is it difficult for you to do strenuous household or yard work? (F)	☐ Yes	☐ Sometimes	☐ No
15	Because of your problem, are you afraid people may think you are intoxicated? (E)	☐ Yes	☐ Sometimes	☐ No
16	Because of your problem, is it difficult for you to walk by yourself? (F)	☐ Yes	☐ Sometimes	☐ No
17	Does walking down a sidewalk increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No
18	Because of your problem, is it difficult for you to concentrate? (E)	☐ Yes	☐ Sometimes	☐ No
19	Because of your problem, is it difficult for you to walk around your house in the dark? (F)	☐ Yes	☐ Sometimes	☐ No
20	Because of your problem, are you afraid to stay home alone? (E)	☐ Yes	☐ Sometimes	☐ No
21	Because of your problem, do you feel handicapped? (E)	☐ Yes	☐ Sometimes	☐ No
22	Has your problem placed stress on your relationships with members of your family or friends? (E)	☐ Yes	☐ Sometimes	☐ No
23	Because of your problem, are you depressed? (E)	☐ Yes	☐ Sometimes	☐ No
24	Does your problem interfere with your job or household responsibilities? (F)	☐ Yes	☐ Sometimes	☐ No
25	Does bending over increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No