

HEARING & BALANCE

— D O C T O R S —

1054 E. Riverside Dr. Suite 201
St. George, UT 84790
Phone: (435) 688-8991

Balance Test

You are scheduled to have a test of your balance system on _____ at _____. The test will take approximately 2 (two) hours. The purpose of this test is to further evaluate complaints of dizziness, poor equilibrium, and certain hearing problems. The test attempts to distinguish the source of your problem; one ear, both ears, the brain, or other parts of the balance system. The test is not painful. However, on occasion, some patients report feeling slightly dizzy for a brief moment following the test, so we suggest you arrange for someone to drive you home after the testing is complete.

In order to obtain the most valid, highest quality results from the test, and for your comfort, you are asked to please comply with the following instructions:

1. **Do NOT wear make-up (including eyeliner or mascara) or use facial moisturizers or face creams the day of the test.** Wear loose, comfortable clothing and flat-heeled shoes for the test.
2. Accurate inner ear function testing requires any medications that act on your central nervous system be **discontinued 48 hours prior to the test:** (complete list on the next page)
 - a. **Sedatives:** Dalmane, Seconal, Nembutal, Phenobarbital
 - b. **Motion Sickness:** Antivert, Dramamine, Meclizine, Bonine
 - c. **Antihistamines:** Benadryl, Dimetapp, CIM, Drixoral
 - d. **Tranquilizers:** Valium, Traxene, Xanax
 - e. **Antidepressant Mood Elevators**
 - f. **Sleeping Pills**

Do NOT discontinue medicines prescribed for heart or kidney problems, high blood pressure, circulatory disorders, blood thinners, breathing disorders, diabetes, cancer, arthritis (non-narcotics), seizures, or hormone imbalance. You may also continue vitamins, steroids, antibiotics, water pills (diuretics). You may take over-the-counter painkillers such as Tylenol, Advil, Ibuprofen, Aspirin, Acetaminophen, etc. Please call us if you have any questions.

3. Abstain from alcohol and caffeine for **48 hours** before the test. Products containing caffeine include many soft drinks, coffee, tea, cola, and chocolate.
4. If medically possible, abstain from food and drink for four (4) hours before the test. If you must eat, keep the meal light.

There are three forms behind this letter. Please complete the front and back of each form and bring them with you to your appointment. You may contact our office if you have any questions, or if you require additional information about the test by calling us at **(435) 688-8991**; we will be happy to answer any of your questions. If you need to cancel your appointment for any reason, please contact our office **24 hours in advance to avoid a \$100 cancellation fee.** We look forward to seeing you! Our office is located at:

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Medication Discontinuation List

Do not take any of the following medications for 48 hours prior to your VNG test date. If you have any questions or concerns about stopping any of your medications, please contact your pharmacist or prescribing physician. If it was recommended that you not cease any of the following medication, please let the clinic know during your appointment.

Anti-Dizziness medications:

- Antivert, Bonine (meclizine)
- Benadryl (diphenhydramine)
- Dramamine (dimenhydrinate)
- Transderm Scop Patches (scopolamine)
- Vontrol (diphenidol)

Anti-Nausea Medications:

- Phenergan (promethazine)
- Ondansetron (zofran)

Anticonvulsants:

- Klonopin (do not stop for anxiety)
- Dilantin (phenytoin) Librium, Librax
- Tegretol (carbamazepine) Nembutal
- Lamotrigine (lamictal)

Antidepressants:

- Ativan (lorazepam)
- Elavil (amitriptyline)
- Lithium
- Pamelor (nortriptyline)
- Placidyl (ethchlorvynol)
- Prozac (fluoxetine)
- Valium (diazepam)
- Xanax (alprazolam)

Antihistamine/decongestants:

- Allegra (fexofenadine)
- Benadryl
- Chlor-Trimeton
- Claritin (loratadine)
- Sudafed (pseudoephedrine)
- Zyrtec (cetirizine)

Sleeping medications:

- Ambien (zolpidem)
- Dalmane (flurazepam)
- Doral (benzo)
- Halcion (benzo)
- ProSom (estazolam)
- Restoril (temazepam)
- Secobarbital(seconal)
- Unisom (diphenhydramine)

Stimulants:

- Amphetamine
- Ritalin (methylphenidate)
- Adderall

Headache medications:

- Fiorinal (butalbital)
- Lamictal
- Imitrex (sumatriptan)

Others:

- Methadone
- Celebrex-
- Quinine (qualaquin)

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Patient Registration

Patient's Name _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Date of Birth ____ / ____ / ____ Gender _____ Marital Status _____

Spouse or Relative _____ Relationship _____ Phone _____

Referring Physician _____ Dr. Phone # _____

Primary Care Physician _____ Dr. Phone # _____

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

For patients under 18 years of age

Responsible Party _____ Relationship to Patient _____

Address _____ Home Phone _____
Street City State Zip

How did you hear about us? Friend _____ Doctor _____
 Google Search Facebook YouTube Instagram Online Ad Other _____

Please Initial

_____ I certify this information is true and correct to the best of my knowledge, and I hereby consent to treatment by the providers of Hearing & Balance Doctors of Utah. I understand that diagnostic testing done will be billed to my insurance I have read the terms and conditions of the Billing Agreement and the Notice of Privacy Practices, and hereby agree to abide to all terms and conditions as outlined. I hereby authorize the release of all pertinent information including diagnosis, examination records and treatment records to authorized persons. These records will be held in strict confidence and are not available to unauthorized persons. Hearing and Balance Doctors of Utah may use my home address and/or e-mail address to communicate current and future technology updates and offers related to my treatment.

_____ I understand that Cerumen (wax) removal from the ear canal is not eligible for reimbursement by my insurance. There is a \$25 charge per ear for minimal/marginal wax levels, a \$50 charge per ear for severe wax levels and a \$100 charge per ear for significantly compacted wax levels.

Signed _____ Date _____

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Patient Name _____ Date _____

1. Please describe your symptoms:

2. When did these symptoms begin?

3. Did your symptoms come on gradually or suddenly?

4. Have symptoms become worse (more frequent or more severe) or have they improved?

5. Check all that apply to your dizzy spells:

- | | |
|--|--|
| <input type="checkbox"/> Preceded by flu or cold | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Spinning sensation | <input type="checkbox"/> Swimming sensation |
| <input type="checkbox"/> Falling to one side | <input type="checkbox"/> Dizzier in certain positions |
| <input type="checkbox"/> Trouble walking in the dark | Which positions: _____ |
| <input type="checkbox"/> Comes in attacks | <input type="checkbox"/> Dizzy when lying down |
| How often? _____ | <input type="checkbox"/> Better if you sit or lie perfectly still |
| How long? _____ | <input type="checkbox"/> Fullness, pressure, or ringing in your ears |
| <input type="checkbox"/> Free from dizziness between attacks | <input type="checkbox"/> Imbalance |
| <input type="checkbox"/> Nausea | |

6. Check all that apply to other sensations you may have:

- | | |
|---|--|
| <input type="checkbox"/> Blacking out or fainting when dizzy | <input type="checkbox"/> Tingling around mouth |
| <input type="checkbox"/> Dizzy or unsteady constantly | <input type="checkbox"/> Spots before eyes |
| <input type="checkbox"/> Severe or recurrent headaches | <input type="checkbox"/> Jerking of arms and legs |
| <input type="checkbox"/> Double or blurry vision | <input type="checkbox"/> Confusion or memory loss |
| <input type="checkbox"/> Numbness in face or extremities | <input type="checkbox"/> Dizzy when stand up quickly |
| <input type="checkbox"/> Weakness or clumsiness in arms, legs | <input type="checkbox"/> Weakness/faintness a few hours after eating |
| <input type="checkbox"/> Slurred or difficult speech | |
| <input type="checkbox"/> Difficulty swallowing | |

7. Check all that apply to your hearing and circle which ear is affected:

- | | | | |
|--|------------|---|------------|
| <input type="checkbox"/> Difficulty hearing | Right/Left | <input type="checkbox"/> Previous ear infections | Right/Left |
| <input type="checkbox"/> Ringing | Right/Left | <input type="checkbox"/> Change in hearing when dizzy | Right/Left |
| <input type="checkbox"/> Fullness | Right/Left | How _____ | |
| <input type="checkbox"/> Pain | Right/Left | <input type="checkbox"/> Previous ear surgery | Right/Left |
| <input type="checkbox"/> Discharge | Right/Left | When _____ | |
| <input type="checkbox"/> Hearing change | Right/Left | What _____ | |
| <input type="checkbox"/> Exposure to loud noises | Right/Left | | |

8. Check all that apply to your medical history:

- | | |
|---|---|
| <input type="checkbox"/> Head injury with loss of consciousness | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes |
| Medicines: _____ | <input type="checkbox"/> Thyroid Disease |
| Other: _____ | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back or neck injury | <input type="checkbox"/> Other: _____ |

9. Check those that may be linked to your dizziness:

- | | |
|---|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Recent change in eyeglass |
| <input type="checkbox"/> Menstrual period | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Overwork or exertion | <input type="checkbox"/> Diet |

10. Check all that apply to your habits and lifestyle:

- Drink coffee
How much? _____
- Drink tea
How much? _____
- Drink soft drinks?
How much? _____

- Drink alcohol
How much? _____
- Smoke
How much? _____

11. Please list your current medical problems and length of illness.

12. Please list all surgeries and approximate dates.

13. Please list below, or attach a list, of all medications you currently take, including prescription, over the counter, herbals, vitamins & supplements. If attaching a list, please follow the format shown below.

Medication	Dosage	Frequency	Route (ie: oral, injection...)

<p><i>For office use only</i></p> <p>Medications reviewed by: _____</p> <p style="text-align: center;">Provider Initials Date</p>

14. Have you had any of the above medicines in the past 48 hours?

15. What studies have been done previously (hearing tests, head scans, blood work, etc.)?

16. Do you have anything else to tell us about your particular problem that we haven't asked you on this questionnaire?

Patient Signature

Date

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JACOBSEN DIZZINESS INVENTORY

Patient Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes", "Sometimes" or "No" to each question. Answer each question as it pertains to your **DIZZINESS OR UNSTEADINESS ONLY**. Please circle only one.

- | | | | |
|---|---|---|--|
| Y | S | N | 1. Does looking up increase your problem? |
| Y | S | N | 2. Because of your problem, do you feel frustrated? |
| Y | S | N | 3. Because of your problem, do you restrict your recreation/business travel? |
| Y | S | N | 4. Does walking down an aisle of a supermarket increase your problem? |
| Y | S | N | 5. Because of your problem, do you have difficulty getting out of bed? |
| Y | S | N | 6. Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing, or to parties? |
| Y | S | N | 7. Because of your problem, do you have difficulty reading? |
| Y | S | N | 8. Does performing more ambitious activities, like sports, dancing, household chores such as sweeping or putting dishes away, increase your problem? |
| Y | S | N | 9. Because of your problem, are you afraid to leave your home without having someone accompany you? |
| Y | S | N | 10. Because of your problem, have you been embarrassed in front of others? |
| Y | S | N | 11. Do quick movements of your head increase your problems? |
| Y | S | N | 12. Because of your problem, do you avoid heights? |
| Y | S | N | 13. Does turning over in bed increase your problem? |
| Y | S | N | 14. Because of your problem, is it difficult for you to do strenuous housework or yard work? |
| Y | S | N | 15. Because of your problem, are you afraid people may think you are intoxicated? |
| Y | S | N | 16. Because of your problem, is it difficult for you to walk alone? |

PLEASE TURN OVER AND COMPLETE THE REVERSE SIDE

- | | | | |
|---|---|---|--|
| Y | S | N | 17. Does walking down a sidewalk increase your problem? |
| Y | S | N | 18. Because of your problem, is it difficult for you to concentrate? |
| Y | S | N | 19. Because of your problem, is it difficult for you to walk around your house in the dark? |
| Y | S | N | 20. Because of your problem, are you afraid to stay home alone? |
| Y | S | N | 21. Because of your problem, do you feel handicapped? |
| Y | S | N | 22. Has your problem placed stress on your relationships with members of your family or friends? |
| Y | S | N | 23. Because of your problem, are you depressed? |
| Y | S | N | 24. Does your problem interfere with your job or household responsibilities? |
| Y | S | N | 25. Does bending over increase your problem? |

Please mark an "X" on the line corresponding to how intense or how severe the following symptoms are for you at this time. This line represents a number line from 0-10, 0 representing no problem and 10 representing it could not be worse.

How much of a problem or how much is your instability or balance interfering in completing your daily routines?

0-----10

How severe is your dizziness and how much is dizziness interfering with you completing your daily life routines?

0-----10

For Office Use Only

JDI Score: _____

Dizziness Score: _____

Balance Score: _____