210 S. Market St., Suite A
Troy, OH 45373
ph 937-308-7000
fx 937-703-9255

Name: _____

Date: _____

Upper Valley Hearing & Balance Inc.

# Dizziness / Vertigo Questionnaire

Which of the following best describes your dizziness?

- ☐ Lightheaded
- ☐ Swimming sensation
- ☐ Feel that you will pass out
- ☐ Spinning inside
- ☐ Loss of Balance/Stumbling
- ☐ Confusion
- ☐ Tendency to fall: __ to the right __ to the left
- ☐ Objects spinning or turning around you

When you are dizzy, do you have any of these symptoms before, during or after an attack?

- ☐ Nausea
- ☐ Vomiting
- ☐ Headache
- ☐ Double Vision
- ☐ Ringing in the ears
- ☐ Hearing loss
- ☐ Ear pressure
- ☐ Visual changes or spots
- ☐ Pounding in chest
- ☐ Difficulty speaking or swallowing
- ☐ Hunger
- ☐ Flushing
- ☐ Numbness
- ☐ Loss of body control
- ☐ Nervousness
- ☐ Muscle weakness
- ☐ Falling suddenly
- ☐ Loss of consciousness

Do you have a family history of dizziness? _____

How many spells have you had? _____ How long do they last? _____

When was the first attack? _____

Is there anything that will cause an attack? _____

Have you had any treatment for dizziness? If yes, please explain: _____

Is there any hearing loss or ear pain? _____

Any history of ear infection, surgery or popping noise in the ear? _____

Do you have a history of headaches? _____ If yes, please describe: _____

Do you have allergies? _____ If yes, please list: _____

(*Female*) Do you have difficulty with your menstrual cycle? _____ Are you perimenopausal? _____

Have you been exposed to any irritating fumes? _____

Because dizziness is so individual, a description of your symptoms is very helpful. Please describe your dizziness in your own words.

_____

_____

_____

Please call our office at (937) 308-7000 with any questions concerning your tests or the questionnaire.
Thank You, Drs. Kate Lins, Alison Bailey, Mallory Mercer, Stacy Roberts & Jane Rudy

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# Dix-Hallpike Test & Epley Maneuver Waiver

The **Dix-Hallpike Test and Epley Maneuver** are not a covered benefit by insurance.

The test is $30 and the combined test and maneuver is $60; payment is due on the day of service. If VEMP testing is performed, there is a possibility of no insurance coverage for the test.

Thank you.

Patient Name: _____

Patient Signature: _____

By signing this waiver, the patient/guarantor agrees to receive and pay for the service or procedure.

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**Appointment Date and Time**: _____

You have been scheduled to receive one or more of the following special tests to help determine the cause of your symptoms.

____ **Audiometric Evaluation**: This is a standard hearing test that includes speech reception testing. The test provides information as to the function of the outer, middle and inner ear. This test takes about 20 minutes.

____ **Brainstem Evoked Response (ABR)**: This test evaluates the function of the auditory nerve. You will relax wearing earphones and listen to an auditory signal. There is no discomfort. This test takes about one hour.

____ **Electrocochleography (ECOG):** This is a computerized electrode test that evaluates the inner ear. There is momentary slight discomfort. This test takes about one hour.

____ **Video Electronystagmography (VENG):** This test evaluates inner ear balance function. You will wear goggles which will allow us to record eye movement. This test takes about one hour. You may experience some brief periods of dizziness. Except for rare cases, you will have no difficulty driving home after the test. Specific instruction for this test:

- No food or drink for four (4) hours before the test.
- No alcohol for forty-eight (48) hours before the test
- Do not wear makeup, mascara, foundation, or moisturizer on your face.
- No medications for forty-eight (48) hours before the test except for medications that have been approved by the physician. Please discuss any concerns about discontinuation of medications with your physician. Please see following page for a list of medications that you MUST NOT TAKE.

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**MEDICATIONS TO BE STOPPED 48 HOURS BEFORE VNG/ENG TESTING**

***This list is NOT all inclusive.***

If you have any questions regarding your medications, please call our office for verification at least 2 full days before testing.

*Over-the-counter medications:* ALL allergy medications, cold medications, sleep aids, anti-itch creams containing antihistamines, anti-nausea, antibiotics, and cough syrups.

| **Allergy Medications** | | **Pain Medication** | **Dizziness/Nausea/Diarrhea** |
|---|---|---|---|
| Allegra | | Darvocet | Antivert |
| AlleRx | | Demerol | Atarax |
| Antihistamine Sprays | | Dilaudid | Compazine |
| Astelin Nasal Spray | | Lortab | Dramamine |
| Astepro Nasal Spray | | Morphine | Meclizine |
| Benadryl | | Oxycontin | Phenergan |
| Claritin | | Oxycodone | Scopolamine patch |
| Clarinex | | Paxicodone | Zofran |
| Nolamine | | Percocet | **Herbal Remedies** |
| Pataday eye drops | | Phrenilin | Ginkgo |
| Patanase nasal spray | | Topamax | Valerian |
| Triaminic | | Vicodin | |
| Zyrtec | | Wygesic | |
| | | Zydone | |
| **Psychotherapeutic Agents/Antidepressants** | | **Restless Leg** | ***Seizure Meds*** |
| BuSpar | Ritalin | Requip | Dilantin |
| Celexa | Sinequan | Mirapex | Mebaral |
| Clorazil | Sedatives | | Tegretol |
| Concerta | Sleeping Pills | | Phenobarbital |
| Depakote | Stelazine | | ***check with your doctor before stopping these meds.*** |
| Elavil | Strattera | | |
| Haldol | Trazadone | | |
| Klonopin | Triavil | | |
| Librium | Valium | | **Other** |
| Lithium | Vivactil | | Neurontin |
| Miltown | Wellburtrin | | |
| Paxil | Xanax | | |
| Prozac | Zoloft/Zyprexa | | |

**The following list of medications are ok to continue taking:** Heart medication, cholesterol meds, glaucoma, blood pressure meds, thyroid meds, reflux meds, hormone treatment, birth control pills, Imitrex, asthma inhalers, regular/pain Tylenol & Advil, antibiotics, Kaopectate, Imodium, and Pepto Bismol.