HILLCREST
HEARING & BALANCE CENTER
A DIVISION OF SOUTHWEST OHIO ENT SPECIALISTS

Patient Name: _____ Date of Birth: _____

Date of Appointment: _____ Appointment Time: _____

Referring Physician: _____

## Appointment Location:

☐ **MAIN OFFICE:**
1222 S. Patterson Blvd—Suite 400
Dayton, OH 45402
**(937) 222-0022**

☐ **ENGLEWOOD OFFICE:**
9000 N. Main Street—Suite 319
Dayton, OH 45415
**(937) 832-3582**

☐ **CENTERVILLE OFFICE:**
6601 Centerville Business Pkwy. — Suite 200
Centerville, OH 45459
**(937) 435-7476**

☐ **TROY OFFICE:**
1861 Towne Park Drive—Suite H
Troy, OH 45373
**(937) 222-0022**

## Special Test Information Sheet:

*You have been scheduled to have special tests to help determine the cause of your symptoms. You will be having the following tests:*

☐ **Audiometric Evaluation:** *(Testing Code: 92557)*

***PURPOSE:*** A standard hearing test that includes speech testing. This test provides information as to the function of the middle and inner ear.

***WHAT TO EXPECT:*** You will be placed in a soundproof booth with a set of headphones over the ears or small foam insert earphones placed in the ears. You will be asked to convey that you have heard the tone by either raising your hand or pressing a button. The audiologist may also conduct speech tests whereby you will be asked to repeat the words you are hearing.

***TIME:*** This test will last about 30 minutes.

☐ **ABR *(Auditory Brainstem Response):*** *(Testing Code: 92585)*

**PURPOSE:** To measure the function of your hearing nerve.

**WHAT TO EXPECT:** An electrode will be placed behind each ear and on the upper and lower forehead. You will relax and listen to some clicking sounds through small foam insert earphones placed in your ears. There is no discomfort.

**TIME:** This test will last about 30 minutes.

☐ **EcoG *(Electrocochleography):*** *(Testing Code: 92584)*

***PURPOSE:*** To evaluate the pressure build up of your inner ear fluids.

***WHAT TO EXPECT:*** Electrodes are placed on your upper and lower forehead and inside the ear canals. You will relax and listen to some loud clicking sounds through small foam insert earphones placed in your ears. Minimal discomfort may occur in the ear canal.

***TIME:*** This test will last about 30 minutes.

☐ **VEMP*(Vestibular Evoked Myogenic Potential):*** *(Testing Code: 92585)*

**PURPOSE:** To measure the function of your balance nerve.

**WHAT TO EXPECT:** Electrodes will be placed high on your sternum (chest) and on your neck. You will be asked to turn your head, tense your neck muscles, and listen to a brief clicking sound. You may expect some neck discomfort.

**TIME:** This test will last about 30 minutes.

☐ **VNG or ENG *(Video- or Electro-nystagmography):*** *(Testing Codes: 92541,92542,92543,92544,92545,92547)*

***PLEASE FOLLOW SPECIAL INSTRUCTIONS ON THE NEXT SHEET FOR THIS TEST.***

***PURPOSE:*** To test the inner ear's balance function.

***WHAT TO EXPECT:*** A recording will be made of your eye movements in different conditions. During this test we will ask you to perform some visual tasks, lie into different positions, and we will also bathe each ear canal with warm and cool air. You may experience some brief periods of dizziness. Rest assured, the dizziness will subside quickly and in except for rare cases you should have no difficulty driving home after the test.

***TIME:*** This test will last about 1 hour.

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# Special Instructions for <u>VNG or ENG</u> Testing:

Certain substances can influence the body's response to testing, causing an invalid response.
**Therefore, please follow the following test instructions.**

**<u>DAY OF TESTING:</u>**

_____ No food or drink **<u>four (4)</u>** hours before the test (including caffeinated products) to avoid an upset stomach during testing.

_____ Please do not wear eye makeup, foundation, or moisturizer on your face.

_____ Dress Comfortably, Dresses and skirts should be avoided. Slacks and shoes without heels should be worn.

**<u>48 HOURS</u> PRIOR TO TESTING:**

_____No alcohol **<u>48 hours</u>** prior to testing. This includes any quantity of beer, wine, liquor, and cough medicines containing alcohol.

_____The following medications may affect the results of the VNG or ENG: If stopping the medication is approved by the prescribing physician, the medications should be not be taken for **<u>48 hours</u>** prior to the VNG. They can be resumed immediately after the testing. **If these medications cannot be discontinued*, under a physician's direction*, the testing can still be performed.**

- **<u>Anti-Vertigo Medication:</u>** Antivert, Dro-Peridol Drops, Meclizine, Ru-vert, etc.
- **<u>Anti Nausea Medication:</u>** Atarax, Bontrol, Bonine, Bucladin, Compazine, Dramamine, Marezine, Phenergan, Thorazine, Scopalomine Patch, etc.
- **<u>Tranquilizers:</u>** Atarax, Atarazz,Ativan, Elavil, Equanil Etraafon, Klonipin, Librium, Librax, Lorazapam, Miltown, Prozac, Serax, Travil, Tranxene, Valium,Vistaril, Xanax, etc.
- **<u>Muscle Relaxers:</u>** Flexeril, etc.
- **<u>Sedatives:</u>** Butisol, Chloral Hydrate, Dalmane, Doridan, Halcion, Nembbutal, Restoril, Placidly, "pm" pain medications, Quaalude, Seconal, Sleeping pills, etc.
- **<u>Narcotics & Barbituates:</u>** Codeine, Darvocet, Darvon, Demerol, Dilaudid, Florinal, Oxycontin, Oxycodone, Percocet, Percodan, Phenaphen, Rebaxin, Tylenol with Codeine, Vicodin.
- **<u>Anti-Histamines:</u>** Actifed, Allegra, Benadryl, Chlor-Trimeton, Claritin, Comtrex, Dimetane, Dimetapp, Disophrol, Drixoral, Polaraminee, Seldane,Tavist, Teldrin, Temaril, Triaminic, Trinalin, Vistaril, Zyrtec, and any over-the-counter cold remedies, etc.
- **<u>Anti-Seizure Medications:</u>** Dilantin, Tegretol, Phenobarbital, etc.

***This is not a complete list of such medications, so please ask if there are questions about any medications being taken***

**If any of these medications have been taken by the patient for psychiatric, seizure, or other neurologic disorders, <u>they should only be discontinued after consulting with the prescribing physician</u> as stopping these medications suddenly may result in withdrawal symptoms or other serious medical conditions.**

You should continue to take any medications prescribed for you except those categories listed above. You should continue to take all heart and blood pressure medications, hormone medication, Thyroid Medications, Diabetes or Sugar Medications. You may take vitamins, Asprin, Bufferin, Tylenol, etc.

**IF ANY QUESTIONS ARISE REGARDING TEST PROCEDURES OR MEDICATIONS**
***<u>PLEASE CALL THE OFFICE</u>***

(PLEASE TURN THE PAGE AND FINISH THE QUESTIONNAIRE)

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Name: _____

Date of Birth: _____

# DIZZINESS/VERTIGO QUESTIONNAIRE

Which of the Following **Best describes** your symptoms? (Check all that apply)

☐ Lightheaded
☐Swimming Sensation
☐ Tendency to fall to the Right
☐Tendency to fall to the Left
☐ Objects spinning or turning around you
☐ Spinning inside you
☐ Feeling like you will pass out
☐ Loss of Balance
☐ Confusion
☐ OTHER: _____
_____

Before, during, or after your Best Described *(above)* do you experience any of the following? (Check all that apply).

☐ Nausea
☐ Vomiting
☐ Headache
☐ Double Vision
☐ Ringing or Noises in your ears.
☐ Hearing Loss
☐ Ear Pressure
☐ Ear Pain
☐ Visual Changes
☐ Spots before your eyes
☐ Heart pounding in your chest
☐ Difficulty Speaking
☐ Difficulty Swallowing
☐ Hunger
☐Flushing
☐ Numbness
☐ Loss of Body Control
☐ Nervousness
☐ Muscle Weakness
☐ Falling Suddenly
☐ Loss of Consciousness

Please describe your symptoms further:

1) Are your symptoms: ☐A one-time occurrence? ☐Recurrent attacks?
2) How many occurrences of symptoms have you had? _____
3) How long do your symptoms last? _____
4) When was the first occurrence? _____
5) Have you had any injuries to your head or neck? _____
6) Have you had any history of ear infections, ear surgery, or ear problems? _____
7) Is there anything that will cause your symptoms?_____
8) Is there anything that will make your symptoms worse? _____
9) Is there anything that will make your symptoms better? _____
10) Do your symptoms get worse before or after eating? _____
11) Do your symptoms get worse when you are tired or stressed? _____
12) Have you had any treatment for dizziness? _____
13) If you have had treatment for dizziness, with what? _____
14) Did this treatment for dizziness help? _____
15) Do you have any allergies? _____
16) Do you have a family history of dizziness? _____
17) Have you ever been exposed to any irritating fumes? _____
18) Please add any additional information which you feel is important that was not addressed above:

_____
_____
_____