

**Patient Appointment Information – READ NOW PLEASE!**

Our goal is to provide comprehensive evaluation and treatment for a variety of balance disorders including vertigo, disequilibrium, imbalance, and unsteadiness. These symptoms can have many different causes and treatment varies depending on the source of the problem. The evaluation process involves no pain or risk, but may require more than one visit to the center.

The first step in receiving help is to consult your family physician. Frequently they can determine the cause of your balance problems and provide treatment. Your family doctor can help you determine whether you might be a candidate for the Balance Disorders program. Additionally, they will provide us with important information about your medical background and a list of your current medications.

We are a specialty Balance Disorders program and not all components of a comprehensive vestibular evaluation are covered by all health insurances. Our goal is to determine the cause of your dizziness and to help you feel better. We will only perform testing that we feel is helpful in determining the next step in that process. However, please inform us if you do not wish to have such testing.

Typically, your initial appointment will include a medical history review and a detailed interview to “classify” your type of dizziness. Based on these, we will determine which exams are most likely to provide helpful information. In some cases, the initial testing will reveal the problem, but you may be asked to return for additional non-routine testing

**Preparing For Your Appointment**

It is important that you keep your scheduled appointment as we block 2 hours of our schedule for this. If you must change your appointment, please do so at least 24 hours prior. Failure to keep or cancel your appointment in a timely manner may result in the inability to reschedule your appointment.

Prior to your initial appointment, you should have received a questionnaire and registration form. Please fill these out **before** arriving for your appointment.

**If you are not ready to be seen at your scheduled time with paperwork completed, your appointment may need to be rescheduled.** Bring a list of your current medications and any medical records pertaining to your balance or dizziness (particularly reports of any previous exams such as CT or MRI scans, and any recent hearing tests). **You may take your medications normally, but eat lightly before this initial appointment. Refrain from wearing excessive makeup and do NOT wear eye liner or mascara. Try to limit tilting and moving your head excessively for an hour or two prior to your appointment.** Your initial visit usually takes about 1-2 hours.

**Vestibular Tests**

A comprehensive battery of tests will be performed during your appointment. Prior to each test an explanation will be given so that you have a better understanding of what is being tested and why. These tests are designed to help us locate the source of your dizziness or balance disorder. In each of these tests, we stimulate the balance centers of the inner ear or nerve tract connecting the inner ear to the brain. We then record the response to the stimulus. These tests are safe and comfortable, no needles are used, but stimulation of the inner ear may make you temporarily dizzy. You may have a friend or family member stay with you throughout the evaluation.

### **VNG (Videonystagmography)**

Many inner ear disorders cause an involuntary movement of the eyes called nystagmus. This nystagmus can be recorded and analyzed through VNG testing. Stimulation of the inner ear for this test includes rapid position changes of the head and body, and caloric (temperature) stimulation of the inner ear through irrigating the ear canal with different temperatures of water or air. The goal is to determine if both inner ears are functioning and responding equally to the stimulation. Additionally, tests of voluntary eye movement serve as a screening for possible neurologic disorders.

### **Rotational Chair**

Rotational chair testing allows us to stimulate the inner ear and avoid stimulating any other part of the balance system. It is a very sensitive test of inner ear abnormality. The patient is placed in a motorized chair and eye movements are recorded and analyzed as the motorized chair rotates at various speeds.

### **vHIT (Video Head Impulse Test)**

vHIT allows us to measure the accuracy of the Vestibular Ocular Reflex (VOR) to rapid head movements, which is critical for visual stability when moving. The patient visually focuses on a target while the examiner manually makes quick, impulsive movements of the head. The vHIT apparatus allows us to measure head movement and eye movement simultaneously.

### **Skull Vibration Test**

A small hand held vibration device is placed on the mastoid bone just behind the ear, while eye movements are monitored using video goggles. Vibration often causes an abnormal movement of the eyes (nystagmus) if a significant inner ear weakness is present.

### **Cervical and/or Ocular VEMP (Vestibular Evoked Myogenic Potential)**

Surface electrodes are placed on the forehead, under the eyes, or on the neck, and loud sounds are presented to the ears while the patient sits comfortably in a reclining chair. VEMP provides information about otolith structures responsible for sensing vertical and horizontal linear movements.

### **ABR (Auditory Brainstem Response)**

Balance problems can come from the inner ear, the brain, or the nerve pathway between the inner ear and the brain. This test involves recording the transmission of sound traveling up the auditory nerve. Hearing and balance information travel the same nerve pathway. Results of this test can help us identify nerve degeneration, brainstem abnormalities or small auditory nerve tumors that may be affecting balance and/or hearing. If you have had a recent cranial MRI, this test will most likely not be needed.

### **Appointments**

At the completion of your evaluation, we will go over all of your test results and discuss treatment options. Some balance problems can be treated quickly in one or two office visits; however, some require ongoing therapy that typically lasts for several weeks. Some require medical treatment, and we will either refer you back to your physician, or arrange an appointment with the appropriate physician here at Wake Forest Baptist. If your symptoms and tests indicate the likelihood that your complaints are not a result of an ear problem, we will refer you to the appropriate specialist or refer you back to your primary care physician. A report with our findings and recommendations will be sent to the referring physician. We want your visit with us to be as helpful and comfortable as possible, so please don't hesitate to ask any questions.

Updated 10/20

NAME: _____
MRN: _____ DOB: _____

**Balance Disorders**  
**Otolaryngology / Head and Neck Surgery**  
131 Miller St, Winston-Salem, NC 27157

### Dizziness History Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**When** was the first time you ever had dizziness? \_\_\_\_\_

**What** were the circumstances? \_\_\_\_\_

**When** was the last time you experienced dizziness? \_\_\_\_\_

**What** were the circumstances? \_\_\_\_\_

Currently, my dizziness...

- Is constant
- Is always there, but changes in intensity
- Comes in episodes

If comes and goes,

How long does it typically last? \_\_\_\_\_ seconds / minutes / hours (*circle one*)

How often does it typically occur? \_\_\_\_\_ times per hour / day / week / month / year (*circle one*)

My dizziness mostly consists of... (*check ALL that apply*)

- Spells of spinning with nausea
- Off-balance sensation
- A light-headed or near faint sensation
- Other – please explain: \_\_\_\_\_

Between episodes I feel... (*check ONE*)

- Dizzy or off balance all the time
- Normal
- Other – please explain: \_\_\_\_\_

My episodes occur... (*check ALL that apply*)

- Spontaneously. Nothing I do seems to bring them on or turn them off
- Only when standing or walking
- In relation to any head motion
- Only in certain head positions. Please describe: \_\_\_\_\_

When I roll over in bed... (*check ONE*)

- Nothing unusual happens
- The room seems to spin sometimes

Is there anything that you can do to make your dizziness go away? (*sit, lay down, close eyes...*)

Please explain: \_\_\_\_\_



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**Dizziness History Questionnaire, continued**

Circle ALL that apply:

- |  |   |
|--|---|
| I have hearing difficulty <i>Right / Left / Both</i> | I have ringing or other sounds <i>Right / Left / Both</i> |
| I have ear fullness <i>Right / Left / Both</i>       | I have had ear surgery <i>Right / Left / Both</i>         |
| I have tried hearing aids <i>Right / Left / Both</i> |   |

Circle YES or NO:

- Did you have cold, flu or virus type symptoms shortly before the onset of your dizziness ..... YES / NO
- Did you cough, lift, sneeze, fly in a plane, swim under water or have a head trauma shortly before the onset of your dizziness..... YES / NO
- Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?..... YES / NO
- Do you get dizzy when you have not eaten for a long time?..... YES / NO
- Is your dizziness connected with your menstrual period? ..... YES / NO
- Did you get new glasses recently? ..... YES / NO
- I consider myself to be an anxious or tense type of person ..... YES / NO

In the past year I have had... (*check ALL that apply*)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Loss of consciousness                | <input type="checkbox"/> occasional loss of vision     | <input type="checkbox"/> seizures or convulsions          |
| <input type="checkbox"/> Severe pounding headache or migraine |  | <input type="checkbox"/> slurring of speech               |
| <input type="checkbox"/> Difficulty swallowing                | <input type="checkbox"/> palpitations of the heartbeat | <input type="checkbox"/> weakness in one hand, arm or leg |
| <input type="checkbox"/> Tingling around mouth                | <input type="checkbox"/> double vision                 | <input type="checkbox"/> tendency to fall                 |
| <input type="checkbox"/> Spots before the eyes                | <input type="checkbox"/> loss of balance when walking  |   |

I have or have had... (*check ALL that apply*)

- |  |                                    |  |
|--|------------------------------------|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> stroke    | <input type="checkbox"/> high blood pressure       |
| <input type="checkbox"/> Migraine headaches  | <input type="checkbox"/> arthritis | <input type="checkbox"/> a neck and/or back injury |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> allergies |  |

Please check below for any medications you have tried for dizziness or are currently taking:

	Taken in past	Taking now	Helps?
Antivert (Medlazine)	_____	_____	_____
Valium (Diazepam)	_____	_____	_____
Dyazide "water pills"	_____	_____	_____

Have you ever been previously evaluated for dizziness?

Where? When? \_\_\_\_\_

Have you had a recent hearing test?

Where? When? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interpreter Signature/ID# (*if applicable*): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Staff/Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



## DESMOND FALL RISK QUESTIONNAIRE

Please answer all questions.

Name \_\_\_\_\_ Date \_\_\_\_\_

YES NO

1.   Have you had a fall or near fall in the past year?
2.   Do you have a fear of falling that restricts your activity?
3.   Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
4.   Do you feel uneasy or unsteady when walking down the aisle of a supermarket or in an area congested with other people?
5.   Do you have difficulty walking in the dark or on uneven surfaces such as gravel or a sloped sidewalk?
6.   Do your feet or toes frequently feel unusually hot or cold, numb or tingly?
7.   Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
8.   Do you experience loss of balance or a lightheaded/faint feeling when you stand up?
9.   Do you take medication for depression, anxiety, nerves, sleep or pain?
10.   Do you take four or more prescription medications daily?
11.   Do you feel like your feet just won't go where you want them to go?
12.   Do you feel like you can't walk a straight line or are pulled to the side while walking?
13.   Has it been longer than six months since you participated in a regular exercise program?
14.   Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
15.   Are you interested in improving your balance and mobility?

## SHORT FORM QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle the number that **BEST** describes your symptoms. Circle **ONLY ONE** number.

1. The room spins for less than one minute when I lie down, roll over in bed, or tilt my head back.
2. I get temporarily dizzy, light-headed or off-balance when I stand up, worse if I stand quickly.
3. I have had several episodes of severe vertigo with nausea lasting for hours at a time, with fullness and noise in one ear that increases when I am dizzy.
4. I have had several episodes of severe vertigo lasting hours at a time, sometimes accompanied by headache and/or sensitivity to light.
5. I had an episode of constant spinning vertigo and nausea for one to three days, and I feel like I have not recovered back to normal yet.
6. I am unsteady whenever and as long as I am on my feet. I am fine while sitting or lying down.
7. I don't really feel dizzy or off balance, but I am afraid of falling (or have already fallen).
8. None of these describe my symptoms.

If you have circled more than one number, please go back and correct.

On a scale of 1 to 10, with 1 being mildly annoying, and 10 being debilitating and life-altering, how would you rate the severity of your dizziness or imbalance? \_\_\_\_\_