Jefferson Health®

Instructions for Balance Testing

Name: _____ DOB: _____

Appointment Date: _____ Time: _____

You have an appointment to have your balance/dizziness symptoms evaluated. Please arrive **15 minutes** before your scheduled appointment. **Testing can take up to 2 hours.** Please bring your insurance card, an order from the requesting physician (if not seeing one of our physicians), and referral if needed. Many insurances require this information for billing purposes. Your appointment is scheduled at:

☐ Department of Otolaryngology
Balance & Hearing Center
925 Chestnut Street, 6th Floor
Philadelphia, PA 19107
215-955-6760

☐ Jefferson at Cherry Hill
2211 Chapel Avenue West, Suite 403
Cherry Hill, NJ 08002
856-922-5030

Certain medications will affect the results of this test. We request that you stop taking the following medications approximately 48 hours prior to your visit. If you have any questions or concerns, please contact your PRESCRIBING physician. If, for any reason, you cannot go off the medication, please let your clinician know prior to the start of testing.

- dizziness medications (including but not limited to Meclizine, Valium, Scopolamine)
- sedatives (sleeping medications)
- muscle relaxers
- tranquilizers
- antihistamines (including allergy medications)
- antidepressants (including but not limited to Prozac, Lexapro, Paxil, Celexa)
- anti-anxiety medications (including but not limited to Klonopin, Restoril, Valium, Xanax)
- certain prescription pain medications
- tobacco products
- caffeine (Coffee, Tea, Chocolate)
- alcohol (Beer, Wine, Liquor)
- energy drinks

In addition to the above list:

- wear comfortable clothes
- do not wear any eye make-up or face lotions
    - you will be asked to remove any eye make-up prior to testing
- do not eat anything approximately 3-4 hours prior to testing. If you are a diabetic, you may eat a light snack
- we recommend you bring someone with you

We do our best to put your mind at ease and help you through the testing process. If you have any questions regarding these instructions or need to reschedule, please do not hesitate to contact our office at 215-955-6760.

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Balance Function Testing – What to Expect

Our balance system is comprised of three parts: 1) inner ear/vestibular system, 2) visual inputs, and 3) somatosensory input/sensation from the feet and ankles. Vestibular/balance function testing will help us evaluate whether it is your inner ear that is contributing to your dizziness/balance difficulties.

Videonystagmography (VNG)

- video goggles will be placed on your head to track your eye movements
- throughout testing, you will need to keep your eyes OPEN and try to keep from blinking
- sometimes you will be asked random questions—the purpose is to distract your brain from overriding your eye movements

1. You will be asked to complete several tasks while looking at a TV screen which will allow the audiologist to evaluate the connection between your eyes and your inner ears.
    a. following a light as it moves smoothly from side to side
    b. keeping track of a jumping light
    c. looking at bright stripes or squares moving side to side
2. You will be instructed to move into certain positions to check whether that causes dizziness.
    a. lying on your back with your head hanging off the table
    b. turning your head while lying down
    c. rolling over while lying down
3. Lastly, we will be irrigating your ears with warm and cool water or air to test the function of a specific part of your inner ear responsible for side-to-side motion.
    a. this is considered the gold standard of testing and it is especially important that we obtain results from both ears
    b. you may feel like you are spinning or turning and that is **EXPECTED**; just know that the feeling is **NORMAL** and will pass

Cervical/Ocular Vestibular Evoked Myogenic Potentials (cVEMP/oVEMP)

- evaluates the part of your inner ear responsible for up-and-down and/or side-to-side motion
- the sides of your neck, top of your chest, forehead, under-eye area, and nose will be scrubbed and electrode stickers will be attached
- a loud (but safe) thumping noise will be played in each ear
- you will lift your head off the pillow and turn it to the side for ~20 seconds (cVEMP)
- you will look toward the ceiling with your eyes for ~30 seconds (oVEMP)

Electrocochleography (EchoG)

- indirectly measures the endolymphatic (fluid) pressure of the inner ear
- your forehead and ear canals will be scrubbed for electrode sticker/insert placement
- you will be resting with your head on a pillow—you may fall asleep
- you will hear clicking sounds

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Balance Function Testing – What to Expect *(continued)*

Rotary Chair (RVT)

- evaluates the part of your inner ear that is responsible for side-to-side motion
- results of this test will inform the audiologist whether or not there is a weakness in the balance system of one or both of your ears
- you will be seated and secured in a chair that rotates slowly in different directions while wearing video goggles to track your eye movements

Video Head Impulse Test (vHIT)

- evaluates for possible reduction in vestibular function between ears
- emerging test capable of evaluating all six semi-circular canals and is thus the most comprehensive evaluation of the vestibular system
- you will be seated and wearing video goggles to track your eye movements while the audiologist will move your head in different directions

If you have a question about any of these tests or procedures please call our office at 215-955-6760 and ask to speak with an audiologist.

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Dizziness/Balance Questionnaire

Jefferson Balance and Hearing Center

Patient Name:

DOB: (AGE) Gender:

MRN:

Patient Name: _____ **D.O.B.** _____

Please describe in your own words, the sensation you feel without using the word "dizzy":

_____

_____

Please circle the symptom that brought you here today:

Spinning in circles Falling to one side World spinning around me

Please circle:

YES NO My dizzy spells come in attacks

Date of first attack: _____

How often (pick ONE):

- ☐ Less than once a month
- ☐ At least once a month, but less than weekly
- ☐ At least once a week, but not daily
- ☐ Daily
- ☐ It varies greatly

How long is the attack (pick ONE): _____

- ☐ Less than 3 min
- ☐ More than 3 but less than 15 min
- ☐ More than 15 but less than 59 min
- ☐ More than 1 but less than 12 hours
- ☐ More than 12 hours but less than 1 week
- ☐ Weeks to months
- ☐ They vary greatly

YES NO I have a constant spinning in my head

YES NO I am dizzier in certain positions

Which position: _____

YES NO I am free from dizziness between attacks

YES NO My hearing changes with an attack

YES NO I am dizzy if I stand up quickly

YES NO I am nauseated during an attack

YES NO I have had a recent cold or flu

YES NO I have had fullness, pressure, or ringing in my ears

YES NO I have had pain or discharge in my ears

YES NO I have trouble walking in the dark

YES NO I am better if I sit or lie perfectly still

YES NO Loud sounds make me dizzy

YES NO I black out or faint when dizzy

YES NO I have severe or recurrent headaches

IMPORTANT: DO NOT WRITE IN MARGINS

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Dizziness/Balance Questionnaire

Jefferson Balance and Hearing Center

Patient Name:

DOB: (AGE) Gender:

MRN:

YES NO I am sensitive to light during my headaches and/or dizziness
YES NO I have double or blurry vision
YES NO I have numbness in my face or extremities
YES NO I have weakness or clumsiness in my arms/legs
YES NO I have slurred or difficult speech
YES NO I have difficulty swallowing
YES NO I have tingling around my mouth
YES NO I see spots before my eyes
YES NO I have jerking of my arms/legs
YES NO I have seizures
YES NO I have confusion or memory loss
YES NO I have had recent head trauma

The following refer to your hearing. Indicate which side has been affected:

YES NO I have difficulty hearing Left Right Both
YES NO I have ringing Left Right Both
YES NO I have fullness Left Right Both
YES NO I have a change Left Right Both

Have you had any of the following:

YES NO Pain in ears Left Right Both
YES NO Discharge in ears Left Right Both
YES NO Exposure to loud noise Left Right Both
YES NO Ear infections Left Right Both
YES NO Trauma to ears Left Right Both
YES NO Previous ear surgery Left Right Both
Describe: _____
YES NO I have a family history of deafness Left Right Both

The following refer to habits and lifestyle:

YES NO There is added stress to my life recently
YES NO I am dizzy or unsteady constantly
My dizziness is related to:
YES NO Moments of stress
YES NO Menstrual period
YES NO Overwork or exertion
YES NO I feel lightheaded when I am dizzy
YES NO I breathe faster or deeper when excited or dizzy
YES NO I recently changed eyeglasses
YES NO I feel weak or faint a few hours after eating
YES NO I drink coffee
How much _____

IMPORTANT: DO NOT WRITE IN MARGINS

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Dizziness/Balance Questionnaire

Jefferson Balance and Hearing Center

Patient Name:

DOB: (AGE) Gender:

MRN:

YES NO I drink tea
How much _____

YES NO I drink soft drinks
How much _____

YES NO I drink alcohol
How much _____

YES NO I smoke
What _____ How much _____

YES NO I previously smoked
What _____ How much _____

MEDICAL HISTORY:

Please list your current medical problems and length of illness: _____

_____

_____

Please list all surgery performed and approximate date: _____

_____

_____

Please list all allergies (including drugs) and reaction: _____

_____

_____

Please list all medications you currently take (including over the counter meds): _____

_____

_____

Please list previous testing (hearing, x-rays, head scans, etc.): _____

_____

_____

FAMILY HISTORY: (Please specify relationship to you)

YES NO Migraine _____
YES NO High blood pressure _____
YES NO Low blood pressure _____
YES NO Diabetes _____
YES NO Low blood sugar _____
YES NO Thyroid disease _____
YES NO Asthma _____
YES NO Other diseases _____

IMPORTANT: DO NOT WRITE IN MARGINS

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Dizziness/Balance Questionnaire

Jefferson Balance and Hearing Center

Patient Name:

DOB: (AGE) Gender:

MRN:

IMPORTANT: DO NOT WRITE IN MARGINS

SYSTEM REVIEW: Circle all symptoms you currently experience:

Constitutional:
- Recent weight change
- Fever
- Fatigue

Eyes:
- Loss of vision
- Pain
- Discharge/tearing

Ear, Nose, Mouth, Throat:
- Itchy ears
- Nosebleed
- Loss of sense of smell
- Mouth growth, ulcer
- Pain on swallowing
- Voice changes
- Facial weakness
- Nasal obstruction
- Sneezing
- Growth in nose
- Chewing difficulty
- Heartburn
- Breathing difficulty
- Snoring
- Drooling
- Stuffy nose
- Bleeding from throat
- Lump in neck
- Sore throat
- Nasal discharge
- Dental problems

Cardiovascular:
- Chest pain
- Irregular heart beat
- Swelling of legs
- Leg pain with walking
- Leg pain with rest

Respiratory:
- Wheezing
- Cough
- Shortness of breath
- Mucous
- Coughing up blood

Gastrointestinal:
- Decrease in appetite
- Diarrhea/Constipation
- Nausea/Vomiting
- Indigestion
- Blood in stool

Musculoskeletal:
- Neck pain
- Joint pain/Stiffness
- Arthritis
- Name joint(s) _____
- Food intolerance

Skin:
- Rash
- Jaundice
- Recent Baldness

Neurological:
- Headache
- Tremor
- Blackout Seizures
- Paralysis

Psychiatric:
- Insomnia
- Depression
- Excessive sweating

Endocrine:
- Thyroid trouble
- Heat/Cold intolerance
- Excessive thirst, hunger, urination

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Dizziness/Balance Questionnaire

Jefferson Balance and Hearing Center

Patient Name:

DOB: (AGE) Gender:

MRN:

Genitourinary:

- Painful urination
- Difficulty passing urine
- Venereal disease
- Incontinence
- Blood in urine

Hematologic/Lymphatic:

- Bleeding problems
- Anemia
- Easy bruising
- Blood disorder
- Frequent urination at night

Do you have anything else to tell us about your problem that we have not asked on this questionnaire?

_____

_____

_____

_____

_____ _____ _____ _____

Provider Signature Print Name Date Time

IMPORTANT: DO NOT WRITE IN MARGINS