COLORADO
HEARING SPECIALISTS, INC.
9397 Crown Crest Blvd. Ste #307
Parker, CO 80138
Telephone: (720) 842-1890

William O. Dickey, M.D. _____ John P. Molina, Au.D

Appointment Day:_____Date:_____Time:_____

BALANCE TEST INSTRUCTIONS

You are scheduled for an Electronystagmography (ENG) evaluation. This test involves the attachment of electrodes adjacent to each eye and on the forehead. Test procedures require you to look at a variety of spots, swinging pendulums, and a rotating drum. In addition, we will place your head and body in several positions, thus, you may want to wear comfortable clothing. The final aspect of the test involves placing a very small balloon in your ear canal which stimulates your inner ear, and will possibly cause some dizziness. The dizziness usually lasts only a few minutes. There is no pain involved in any of the above procedures. The evaluation will take approximately 1 to 1½ hours.

Since certain medications can affect the results of these tests, it will be necessary for you to **AVOID** taking any of the following medications or beverages for at least 24 hours prior to your appointment time:

1. Sleeping Pills
2. Tranquilizers
3. Antihistamines
4. Barbiturates
5. Alcoholic Beverages
6. Anti-dizzy Medications – (48 hours)
7. Sedatives
8. Muscle Relaxants

Eat a very light meal if your appointment is one after eating (i.e. avoid toast, and heavy/greasy foods).

No more than one cup of coffee or tea 4 hours before test.

No smoking 4 hours before test.

Female patients should not wear make-up, and would be more comfortable in slacks.

If you have any questions, or need to cancel, please call the office location where your test is scheduled at the above phone numbers. **If you need to cancel your appointment, please notify us at least 24 hours in advance.**

COLORADO
HEARING SPECIALISTS, INC.
9397 Crown Crest Blvd. Ste #307
Parker, CO 80138
Telephone: (720) 842-1890

William O. Dickey, M.D. John P. Molina, Au.D.

VERTIGO QUESTIONNAIRE

Name:_____Date:_____

I. When you are "dizzy", do you experience any of the following sensations? Please read the entire list first, then circle yes or no to describe your feelings most accurately.

Yes No 1. Light-headedness or swimming sensation in the head.
Yes No 2. Blackening out or loss of consciousness.
Yes No 3. Tendency to fall: to the right?
to the left?
Forward?
Backward?
Yes No 4. Objects spinning or turning around you.
Yes No 5. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
Yes No 6. Loss of balance when walking: veering to the right?
veering to the left?
Yes No 7. Headache.
Yes No 8. Nausea or vomiting.
Yes No 9. Pressure in the head.

II. Please circle yes or no, and fill in the blank spaces. Answer all questions.

Yes No 1. My dizziness is: Constant?
In Attacks?
2. When did the dizziness first occur?_____
3. If in attacks:
How often?_____
How long do they last? _____
Yes No 4. Do you have any warning that the attack is about to start?
Yes No 5. Are you completely free of dizziness between attacks?
Yes No 6. Does a change of position make you dizzy?
Yes No 7. Do you have trouble walking in the dark?
Yes No 8. When you are dizzy, must you support yourself while standing?
Yes No 9. Do you know of any possible cause of your dizziness?
What:_____

Yes No 10. Do you know of anything that will:
Stop your dizziness or make it better?
Make you dizziness worse?
Yes No 11. Do you have any allergies?
List types:_____
Yes No 12. Did you ever injure your head?
If so were you unconscious?
Yes No 13. Do you take any medications regularly?
List types:_____
Yes No 14. Do you use tobacco in any form?
How much?_____
How often? _____

III. Do you have any of the following symptoms? Please circle yes or no, and circle ear involved.

Yes No 1. Difficulty hearing. Both ears Right Left
Yes No 2. Noise in your ears. Both ears Right Left
If so, describe the noise:_____
Does the noise change with dizziness?
If so, how?_____
Yes No 3. Fullness or stuffiness in ears? Both ears Right Left
Yes No 4. Pain in your ears. Both ears Right Left
Yes No 5. Discharge from ears. Both ears Right Left

IV. Have you experienced any of the following symptoms? Please circle yes or no, and circle if constant or if in episodes.

Yes No 1. Double vision, blurred vision, or blindness. Constant In episodes
Yes No 2. Numbness of face or extremities. Constant In episodes
Yes No 3. Weakness in arms or legs. Constant In episodes
Yes No 4. Clumsiness in arms or legs. Constant In episodes
Yes No 5. Confusion or loss of consciousness. Constant In episodes
Yes No 6. Difficulty swallowing. Constant In episodes
Yes No 7. Difficulty with speech. Constant In episodes
Yes No 8. Pain in neck or shoulder. Constant In episodes

_____
Patient Signature Date