SCENT
SOUTH - COAST - EAR - NOSE - THROAT
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DRS. BERGHASH & LANZA, P.L. D/B/A
South Coast Ear, Nose & Throat
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JACOB W. ZEIDERS III, M.D.*
*BOARD CERTIFIED

Several tests will be performed during your appointment. *We strive to make your visit comfortable and educational*. Once your evaluation is complete a report will be forwarded to your physician.

INFORMED CONSENT AGREEMENT

During a portion of the balance testing you will be asked to follow a series of lights with your eyes. You will be directed to move into different head and body positions while your eye movements are observed. During the final part of the test, cool and warm air will be introduced into your ear canals while your eye movements are observed. This may cause a sensation of motion which will dissipate quickly.

Signature of Patient or Legal Guardian_____ Date:_____
Patient or Legal Guardian Printed Name:_____Signature of Witness:_____

Patient Instructions

- **VERY IMPORTANT: Bring completed Balance Questionnaire to your appointment.**
- We encourage you to have someone bring you to and from the appointment as a sensation of motion may linger. However, if this is not possible, please include an extra 15-30 minutes after your test before leaving the office.
- Do not wear contacts, makeup or use face lotions.
- Wear comfortable clothing. Skirts and/or dresses are not recommended.

12 hours prior to the test

- Please eat lightly 12 hours prior to the test - if your appointment is in the morning you may have a light breakfast such as toast or juice. If your appointment is in the afternoon please eat a light breakfast and have a light snack for lunch.
- Avoid caffeine in beverages such as coffee, tea or soft drinks as well as chocolate.

48 hours prior to test

- Certain medications can influence the test results. The list below includes medicines that you should refrain from taking 48 hours (2 days) prior to your test. *If you have any question or concerns about discontinuing any medications, please consult your doctor.*

Alcohol: Liquor, beer, wine, cough medicine. **Analgesics –Narcotics**: Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet. **Anti-histamines**: Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin…any over-the-counter cold remedies. **Anti-seizure medicine**: Dilantin, Tegretol, Phenobarbital. **Anti-vertigo medicine**: Antivert, Ru-vert, Meclizine. **Anti-nausea medicine**: Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal. **Sedatives**: Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill. **Tranquilizers**: Valium, Klonopin, Libruim, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanex, Zoloft, Diazepam. (*medication list from "The American Institute of Balance")*

You **MAY TAKE** blood pressure medication, heart medications, thyroid medications, Tylenol, insulin, estrogen. **Always consult with your physician before discontinuing prescribed medication.**

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Balance Evaluation
Patient Questionnaire

Patient Name: _____ Date:_____

Balance disorders can be described as dizziness or vertigo and others with imbalance. In addition, a balance disorder can be accompanied by other symptoms. *Please take the time to fill out the below questionnaire and bring to your appointment.*

****

What medications have you taken in the past 48 hours?

_____
_____
_____
_____

List other medications that you routinely take:

_____
_____
_____
_____

YES	NO	
☐	☐	Have you changed medications recently? If yes, please explain: _____
☐	☐	Have you changed dosages on your medications recently? If yes, please explain: _____

****

When did your balance problem first occur?_____
How long did it last?_____
Please describe it without using the word dizzy: _____
_____
_____
_____

---over---

Please answer each of the following:

YES	NO	
☐	☐	Have you been told you had shingles?
☐	☐	Have you ever had migraine headaches?
☐	☐	Has a parent or sibling had migraine headaches?
☐	☐	Are you sensitive to sound?
☐	☐	Are you sensitive to light?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Does your imbalance/dizziness get worse with exertion?
☐	☐	Have you had a recent cold or flu preceding your balance problems?
☐	☐	Are your symptoms connected with your menstrual cycle?
☐	☐	Have you recently started or stopped taking birth control?
☐	☐	Are you going through any hormonal changes?
☐	☐	Have you had a recent change in your eyeglass prescription?
☐	☐	Do you experience motion sickness now or as a child (i.e. airplanes, boats)?
☐	☐	Were you exposed to any solvents, chemical? If yes, what type: _____ _____
☐	☐	Have you had any injuries to your head? If yes, when: _____
☐	☐	Have you had neck or back injury? If yes, when: _____
☐	☐	Are you afraid of falling?
☐	☐	Do you get upset easily?
☐	☐	Is there added stress in your life?
☐	☐	Have you ever fallen? If yes How many times? _____
☐	☐	Do you consume alcohol beverages? If yes, how many: _____
☐	☐	Do you drink coffee, tea or cola products? If yes, how many? _____
☐	☐	Do you know any cause of your balance problem? _____
☐	☐	Do you know of anything that makes your imbalance or spinning, dizziness worse?_____ _____

B. If you have Vertigo or spinning sensations, please fill out the following. <u>If you do not experience spinning or vertigo, please go to section C</u>:

YES	NO	
☐	☐	Does the room and objects spin around you?
☐	☐	Do you spin and the room stays still?
☐	☐	Do you have spinning with your eyes closed?
☐	☐	Do you have spinning with your eyes open?
☐	☐	Is your spinning, dizziness constant?
☐	☐	Does your spinning come in attacks or episodes? If yes: How long does each attack or episode last?_____ Are you free from spinning or imbalance between attacks?_____
☐	☐	Does your hearing change with an attack?
☐	☐	Do you get fullness, pressure or any noises in your ear during an attack?
☐	☐	Are you nauseated during an attack?
☐	☐	Do you know when an attack is about to happen? If yes, describe: _____
☐	☐	Do you get dizzy if you stand or sit up too quickly?
☐	☐	Does the spinning start after a head or body movement? If yes, Which way?_____
☐	☐	Does the spinning happen at a certain time during the day? If yes, When?_____
☐	☐	Can anything stop the dizziness? If yes, please describe: _____

C. Do you experience any of the following?

YES	NO	
☐	☐	Blacking out
☐	☐	Fainting
☐	☐	Loss of consciousness
☐	☐	Light-headedness
☐	☐	Swimming sensations in your head
☐	☐	Nausea or vomitting
☐	☐	Feeling of falling to the right
☐	☐	Feeling of falling to the left
☐	☐	Trouble walking in the dark
☐	☐	Loss of balance when you are walking
☐	☐	Loss of balance when standing up
☐	☐	Pressure in your head

---over---

D. Do you experience any of the following symptoms. If yes, please choose if they are "constant" or occur in "episodes".

YES	NO		If Yes, circle One	
☐	☐	Double Vision?	Constant	Episodes
☐	☐	Spots before your eyes	Constant	Episodes
☐	☐	Cloudiness of vision?	Constant	Episodes
☐	☐	Blurred vision?	Constant	Episodes
☐	☐	Visual jumping?	Constant	Episodes
☐	☐	Numbness of face?	Constant	Episodes
☐	☐	Numbness in arms or legs?	Constant	Episodes
☐	☐	Difficulty with speech?	Constant	Episodes
☐	☐	Difficulty with swallowing?	Constant	Episodes
☐	☐	Tingling around mouth?	Constant	Episodes

E. Do you have any of the following symptoms? If yes, please circle which ear is involved (or both):

YES	NO		If yes, circle one		
☐	☐	Difficulty hearing	Right	Left	Both
		When did this start?_____			
☐	☐	Does the hearing change with your dizziness?	Right	Left	Both
☐	☐	Have you had noise in your ears (tinnitus)?	Right	Left	Both
		If yes, please describe:_____			
☐	☐	Does it change when you are dizzy?			
☐	☐	Stuffiness or fullness in your ears	Right	Left	Both
☐	☐	Pain in your ears?	Right	Left	Both
☐	☐	Discharge from your ears ?	Right	Left	Both
☐	☐	Sensitivity to sound?	Right	Left	Both
☐	☐	Ear surgery?	Right	Left	Both
		What type:_____			
		When: _____			

**************************DO NOT FILL OUT BELOW THIS LINE*********************

AUDIOLOGY COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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