



ADULT AUDIOLOGY, VESTIBULAR TESTING, AND HEARING AID SERVICES
(ENTER AT PROVIDENCE BUILDING LOBBY, PARK AT ST. JOSEPH'S PARKING STRUCTURE ON WEST STEWART DR.)
Office: (714) 639-4991 Fax: (714)221-0978

Instructions for Comprehensive Vestibular Evaluation

The purpose of the Vestibular Evaluation is to determine the cause of your dizziness or balance problem. You are scheduled for a Vestibular Evaluation on (date) _____ at (time) _____. Please arrive 15 minutes early to check in. The test will take approximately three hours. **For your benefit and well being, it is very important that you follow the directions below carefully. Please complete all paperwork prior to arriving to your appointment.** Please call if you should have any questions.

Before the test:

1. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If you have any questions or concerns about discontinuing your medications please consult your physician.
2. The following medications **must not** be taken for at least 48 hours before the test:
 - Anti-nausea medication: Dramamine, Compazine, Bonine, Marezine, Phenergan, Thorazine, etc.
 - Anti-vertigo medication: Antivert, Meclizine, Scopolamine, etc.
 - Diet Pills or Stimulants: Adderall, Ritalin, Ephedrine, No-Doze, etc.

Please discontinue use of the following medications 48 hours before the test unless you have been taking them for 6 months or longer:

- Tranquilizers: Valium (diazepam), Ativan (lorazepam), Xanax (alprazolam), Librium, Atarax, Vistaril, Equanil, Miltown, Triavil, Serax, Etrafon, etc.
 - Sedatives (sleeping pills): Ambien, Nembutal, Seconal, Dalmane, Doriden, Placidyl, Qualude, Butisol, or any other sleeping pills.
 - Narcotics and Barbiturates: Phenobarbital, Codeine, Demerol, Benadryl, Actifed, Teldrin, Triaminic, any over-the-counter cold remedies, etc.
 - Antihistamines: Benadryl, Claritin, Chlortrimeton, Dimetane, Disophrol, Actifed, Teldrin, Triaminic, or any over-the-counter allergy remedies, etc.
 - Quinine (including tonic water)
3. **Do not discontinue** diabetes medications (insulin etc.), heart medications, blood pressure medications, or anti-seizure medications.
 4. **Do not drink alcohol in any quantity within 48 hours of the evaluation, including but not limited to beer, wine, and cough medicines containing alcohol.**
 5. Please do not eat at all 4 hours prior to your appointment, unless you are diabetic: please have a light meal prior to testing and bring snacks if you may need them.
 6. Do not wear make-up, especially eye make-up, or lotion on your face.
 7. Bring your glasses if you need them for distance vision, remove contact lenses during test.
 8. Wear comfortable, loose-fitting clothes.
 9. Testing may cause a sensation of motion that may linger. **If possible we encourage you to have someone accompany you to and from the appointment.**

During the test: A comprehensive battery of tests will be performed for up to three hours. Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. Every attempt will be made to make your visit comfortable.

After the test: Once your evaluation is completed each component is carefully evaluated and reviewed. This process is as important as your test, so please understand that your test results may not be discussed in detail at the time of your evaluation. Once the interpretation has been made a detailed report will be forwarded to you and/or your referring physician.

If you have any questions regarding these instructions, or what to expect on the day of your testing, please do not hesitate to call (714) 639- 4991.

**PROVIDENCE SPEECH AND HEARING CENTER
WORD AND BROWN HEARING CENTER
ORANGE COUNTY FALL PREVENTION AND BALANCE CENTER
ST. JOSEPH HOSPITAL PHYSICAL REHABILITATION SERVICES**

PATIENT QUESTIONNAIRE:

*Your therapist will review this questionnaire.
If you do not understand a question, leave it unanswered.*

Patient Name: _____ Date: _____

Occupation: _____ Daytime Phone #: _____

1. Describe your symptoms: _____

2. When did you first notice your "symptoms"? _____

What caused your symptoms?

☐ No Reason ☐ Reason / Please Explain: *(For example, injury, illness):* _____

How long do your symptoms last? (*circle*) Seconds Minutes Hours Constant

3. Do you **also** experience any of these symptoms **at the same time** as the dizziness? (*Please Circle*)

Ringing in Ears	Fullness in Ears	Fluctuating Hearing	Spinning
Blurred Vision	Headaches	Impaired Balance	Poor Concentration
Memory Loss	Nausea	Vomiting	Lightheaded Feeling
Feeling Foggy	Staggering		

Have you been hospitalized in the last 6 months for these symptoms? _____

4. Do you have any of the following? (*Please Circle*)

Allergies	Depression	Changes in Bowel/Bladder	Rheumatic Fever
Anemia	Diabetes	Lung Disease	Scarlet Fever
Arthritis	Dialysis	Mental Illness	Shortness of Breath
Asthma	Epilepsy	Metal Implants	Stroke
Back Problems	Glaucoma	Migraines	Tuberculosis

Bleeding	Hepatitis	Obesity	Tumors
Blood Clots	High Blood Pressure	Pacemaker	Weakness
Burns	Heart Problems	Phlebitis	Weight loss
Broken Bones	Joint Stiffness	Pregnancy	Head Injury/Trauma
Cancer	Kidney Disease		

Do you have any medical condition that is not listed above? *(Please explain)* _____

5. Have you had any adverse drug reactions?

6. Do you have pain? _____ If yes, where? _____

Please mark your current level of pain _____

0 = No Pain

10 = Severe Pain

Please circle the appropriate pain consistency: Constant Intermittent Sharp Dull Achy Burning

7. What is your acceptable level of pain? _____

8. Do you have any tingling/numbness?

☐ Yes ☐ No If yes, Where? _____

9. What makes your symptoms worse? *(For example: rolling in bed, lying down or sitting up, riding in a car, walking in aisles of supermarket, bending over, changes in diet):* _____

What eases/improves your symptoms? *(For example: lying on my right side, keeping my head still, medication, rest)* _____

10. Do your symptoms disturb your sleep? Yes No

How are your symptoms first thing in the morning? Worse Better Same

How are your symptoms at the end of the day? Worse Better Same

Do you only experience dizziness or lightheadedness when standing from a seated position? _____

11. Since the date of onset/injury, are your symptoms getting:

☐ Worse Better Staying the same

12. Do you live with someone? _____

If yes, who do you live with? _____

Do you have stairs to enter the home? _____

Do you have stairs inside the home? _____

Do you use any assistive devices for walking or general mobility? _____

13. Have you fallen in the past year? Yes No

If yes, when _____ How often have you fallen? _____

14. Do you have any memory problems? Yes No

Are you hard of hearing? Yes No If yes, do you wear hearing aids? _____

Do you have any vision problems? Yes No If yes, do you have glasses or contacts? _____

15. What activities do you normally participate in that you **cannot** currently participate in because of these symptoms? _____

How would you describe your general activity level? _____

16. What are your personal goals or functional expectations from therapy? _____

17. Are you off work now? Yes No

If yes, how long? (*Please give approximate date*): _____

18. Is there any litigation (legal counseling) involved? _____

Patient's Signature: _____

Date: _____

Witness Signature: _____

Date: _____

DIZZINESS HANDICAP INVENTORY (DHI)

Name: _____	Age: _____
Date: _____	Date of Birth: _____

Instructions: Read each question and circle "Yes", "Sometimes" or "No".

1. Does looking up increase your problem?	P	Yes	Sometimes	No
2. Because of your problem, do you feel frustrated?	E	Yes	Sometimes	No
3. Because of your problem, do you restrict your travel for business or recreation?	F	Yes	Sometimes	No
4. Does walking down the aisle of a supermarket increase your problem?	P	Yes	Sometimes	No
5. Because of your problem, do you have difficulty getting into or out of bed?	F	Yes	Sometimes	No
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties	F	Yes	Sometimes	No
7. Because of your problem, do you have difficulty reading?	F	Yes	Sometimes	No
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	P	Yes	Sometimes	No
9. Because of your problem, are you afraid to leave your home without having someone accompany you?	E	Yes	Sometimes	No
10. Because of your problem, have you been embarrassed in front of others?	E	Yes	Sometimes	No
11. Do quick movements of your head increase your problem?	P	Yes	Sometimes	No
12. Because of your problem, do you avoid heights?	F	Yes	Sometimes	No

Continued...

13. Does turning over in bed increase your problem?	P	Yes	Sometimes	No
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	F	Yes	Sometimes	No
15. Because of your problem, are you afraid people might think you are intoxicated?	E	Yes	Sometimes	No
16. Because of your problem, is it difficult for you to go for a walk by yourself?	F	Yes	Sometimes	No
17. Does walking down a sidewalk increase your problem?	P	Yes	Sometimes	No
18. Because of your problem, is it difficult for you to concentrate?	E	Yes	Sometimes	No
19. Because of your problem, is it difficult for you walk around the house in the dark?	F	Yes	Sometimes	No
20. Because of your problem, are you afraid to stay home alone?	E	Yes	Sometimes	No
21. Because of your problem, do you feel handicapped?	E	Yes	Sometimes	No
22. Has your problem placed stress on your relationships with members of your family or friends?	E	Yes	Sometimes	No
23. Because of your problem, are you depressed?	E	Yes	Sometimes	No
24. Does your problem interfere with your job or household responsibilities?	F	Yes	Sometimes	No
25. Does bending over increase your problem?	P	Yes	Sometimes	No

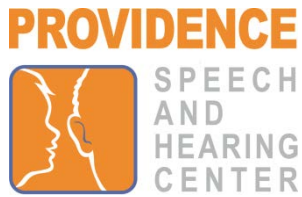
Developed by Dr. G.P. Jacobson and Dr. C.W. Newman, 1990



Scoring: Yes = 4 points; Sometimes = 2 points; No = 0 points

Functional Subscale (F):	/36
Emotional Subscale (E):	/36
Physical Subscale (P):	/28
Total Score:	/100

Key
0 – 30 = Mild Deficit
31 – 60 = Moderate Deficit
61 – 100 = Severe Deficit



PATIENT MEDICATION LIST

NAME: _____ DATE: _____

MEDICATION: List all prescriptions, herbal and over-the-counter medicines you take.

Medication Name	Dose	Frequency	Reason	Last Dose Taken

ALLERGIES: List all allergies to medications, herbs, food, latex, and any other. Describe the reaction.
