Hearing Solutions
AUDIOLOGY & BALANCE CENTER

PATIENT INSTRUCTIONS FOR BALANCE TESTING

You are scheduled for several tests which will evaluate your inner ear balance system.

In order for the test results to be the most accurate representation of the inner ear function, it is important to avoid specific medications and foods/drinks.

For TWO DAYS prior to your examination, you should not take any of the following:

ALCOHOL (beer, wine, liquor or mixed drinks)
CAFFEINE (coffee, tea, soda)
ANTIHISTAMINES (such as benadryl, claritin, allegra, zyrtec)
COLD MEDICINE
NARCOTICS (codeine, percocet, methadone, morphine)
SEDATIVES OR SLEEPING PILLS (such as trazodone, klonopin, ambien, xanax, unisom)
PILLS TO PREVENT DIZZINESS (including antivert, dramamaine or meclizine)
ANTI-NAUSEA MEDICATIONS (phenergan, zofran)
ANTI-DIARRHEA MEDICATION (imodium, pepto-bismol, etc.)

Please DO continue to take any medications that have been prescribed to you by your physician for seizure disorders, heart conditions, high blood pressure, diabetes, or thyroid disease. Continue to take hormones such as estrogen or birth control pills. It is okay to take Tylenol. Always consult with the prescribing physician before discontinuing any prescribed medications.

Do not eat for 2 hours prior to your appointment.

Please do not wear eye makeup such as mascara, eyeliner or eyelash extensions or apply creams or lotions to your face.

Please wear comfortable clothing.

About the testing:

These tests are painless. The test will take between an hour and a half and two hours to complete. One or two of these tests may cause a sensation of motion that may linger. If possible, we recommend you arrange for someone to pick you up following testing. If this is not possible, allow an extra 15-30 minutes after your test before leaving the office.

We will be evaluating the balance sensors in your inner ear. Goggles housing sophisticated cameras will be placed over your eyes and will monitor your eye movements to record nystagmus. Nystagmus is a rapid, involuntary eye movement generated by the balance system. For most tests you will be seated, observing lights. The last portion of testing is called caloric testing. For this portion, you will be lying down and cool/warm air will be introduced to the ear.

A complete report will be sent to your referring physician. If there is a need for balance exercises/rehabilitation beyond what we offer, we will provide the names of some suggested physical therapists.

Please contact the office if you have any further questions or concerns.

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PATIENT INFORMATION

(incomplete forms will delay your appointment)

Name: _____ ☐ MALE ☐ FEMALE
First M. Last

Address: _____ Apt/Unit#: _____

City: _____ State: ____ Zip Code: _____ Home Phone: ( ) _____-_____

Work Phone: _____ Mobile Phone: _____ Email: _____

SS#: _____-_____-_____ Date of Birth: ____/____/_____ Age: _____ Marital Status: _____

IN CASE OF EMERGENCY, CONTACT: _____ Phone: ( ) _____-_____

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Employer: _____ Address: _____ City: _____ State:____ Zip: _____

MEDICAL DOCTOR INFORMATION:

Referring Physician: _____ Phone: ( ) _____-_____

Address: _____City: _____ State: _____ Zip: _____

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM: _____

PLEASE LIST OPERATIONS YOU HAVE HAD: _____

PLEASE NAME ANY MEDICATIONS YOU ARE ALLERGIC TO OR HAVE BEEN ADVISED NOT TO TAKE:

_____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

☐ Heart Disease	☐ Blood Disorders	☐ Artificial Joints	☐ Diabetes
☐ Pacemaker	☐ Breathing Problems	☐ Glaucoma	☐ Stroke
☐ Circulation Problems	☐ Emphysema / COPD	☐ Cancer	☐ Parkinson's Disease
☐ High Blood Pressure	☐ Asthma	☐ Arthritis	☐ Epilepsy / Seizures

Other: _____

ACKNOWLEDGEMENT OF PAYMENT (CHECK ALL THAT APPLY)

☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

☐ Primary Insurance: _____ _____ _____
Name of Insurance ID # Group#

Primary Card Holder Name: _____ Primary Card Holder Date of Birth: ____/____/_____

☐ Secondary Insurance: _____ _____ _____
Name of Insurance ID # Group#

Initial Here

_____ **I understand that I am ultimately responsible for the balance on my account for any professional services rendered.** I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

AUTHORIZATION FOR TREATMENT

The patient /legal guardian authorized The American Institute of Balance staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature:_____ Date:_____

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PATIENT QUESTIONNAIRE

PATIENT NAME : _____ DATE **:** _____

Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES NO

☐ ☐ Do you have migraine headaches?
☐ ☐ Did you have any injuries to your head? When? _____
☐ ☐ If you received a head injury, were you unconscious?
☐ ☐ Have you ever had a neck injury?
☐ ☐ Have you ever fallen? How many times? _____
Where? _____
☐ ☐ Are you afraid of falling?
☐ ☐ Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid)

Medication	Dosage(mg)/Route (mouth, inhaled, injection)	Frequency (How Often)	Purpose/Reason for Medication

☐ ☐ Do you use alcohol?
☐ ☐ Do you smoke? How much? _____

II. If you have dizziness, please check the box YES , and fill in the blank spaces.

YES NO

☐ ☐ My dizziness is constant?
☐ ☐ My dizziness is intermittent? How often? _____
☐ ☐ Do you have any warning that the attack is about to start?
☐ ☐ Is the dizziness provoked by head/body movement? If so, which direction? _____
☐ ☐ Is the dizziness better or worse at any particular time of the day?
If so, when? _____
☐ ☐ Do you know of anything that will stop your dizziness or make it better?
_____
☐ ☐ Do you know of anything that will make your dizziness worse?
_____
☐ ☐ Do you know any possible cause of your dizziness?
_____

III. Do you experience any of the following sensations? Please read the entire list first then check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
☐	☐	Light headedness?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall to the right or left?
☐	☐	Tendency to fall forward or backward?
☐	☐	Loss of balance when walking….. veering to the right?
☐	☐	Loss of balance when walking….. veering to the left?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?

IV. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	Double vision?	Constant	In Episodes
☐	☐	Blurred vision or blindness?	Constant	In Episodes
☐	☐	Spots before your eyes?	Constant	In Episodes
☐	☐	Numbness of face, arms or legs?	Constant	In Episodes
☐	☐	Weakness in arms or legs?	Constant	In Episodes
☐	☐	Confusion or loss of consciousness?	Constant	In Episodes

V. Do you have any of the following symptoms? Please check the box for either YES or NO and circle the ear involved.

YES	NO				
☐	☐	Difficulty in hearing?	Both Ears	Right Ear	Left Ear
			☐Gradual	☐Sudden onset	
		Does the hearing change with your symptoms? If so, how? _____			
☐	☐	Noise in your ears?	Both Ears	Right Ear	Left Ear
		Describe the noise? _____			
		Does the noise change with your symptoms? If so, how? _____			
☐	☐	History of noise exposure? Type: Military, Firearms, Music, Construction_____			
☐	☐	Fullness or stuffiness in your ears?	Both Ears	Right Ear	Left Ear
		Does this change when you are dizzy? _____			
☐	☐	Pain in your ears?	Both Ears	Right Ear	Left Ear
☐	☐	Discharge from your ears?	Both Ears	Right Ear	Left Ear

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

CONSENT TO SHARE PHI (PERSONAL HEALTH INFORMATION)

By signing this form below, I consent to the disclosure of my Protected Health Information to the designated person(s):

I, (Patient Name) _____, **give my permission** to share my PHI with the following person/people:

_____ _____
Print Name Relation

_____ _____
Print Name Relation

CONSENT TO USE E-MAIL TO COMMUNICATE PHI OVER THE INTERNET:

By signing below, I authorize Hearing Solutions Audiology Center to communicate my PHI over the internet via E-Mail for the purpose of providing information pertinent to my healthcare needs (i.e., appointment reminders, medical records release, and marketing, etc.)

Please contact me using the following E-Mail:_____

□ I refuse email communications.

CONSENT TO USE PHI FOR INTERNAL MARKETING:

By signing below, I authorize Hearing Solutions Audiology Center to use my PHI for the purpose of providing information about treatment alternatives or other health benefits and services that may be of interest to me. This information will not be shared with any outside business associates or vendors.

□ I refuse marketing.

CONSENT TO DISCLOSE PHI (PERSONAL HEALTH INFORMATION):

By signing below, I consent to Hearing Solutions Audiology Center's use and disclosure of my Protected Health Information for the purpose of treatment, payment, and/or health care operations and acknowledge that I may request a copy of the Privacy Notice of Hearing Solutions Audiology Center.

_____ _____
Signature of Patient or Legal Representative Relationship to Patient

_____ _____
Print Name Date

_____
Witness