LSU Health
NEW ORLEANS
School of Allied Health Professions
Department of Communication Disorders

You have been scheduled for a vestibular assessment which may include a hearing evaluation, videonystagmography (VNG) evaluation and/or other various tests of balance function and functional impairment. These tests assess your inner ear to determine if some dysfunction or abnormality exists which may be causing your dizziness.

The appointment may take up to 2 hours. Below is a list of instructions that are very important to successfully complete testing during your scheduled appointment time.

PRE-TEST RESTRICTIONS:

- **DO NOT** use the following medications for **48 hours** before testing.
  - Meclizine, Antivert, Dramamine or other medications for dizziness, nausea, or motion sickness
  - Narcotic pain relievers (i.e. Percocet, Vicodin, Codeine, Demerol)
  - Muscle relaxants, sedatives and tranquilizers (i.e. Valium)
  - Sleep Aids (i.e. Ambien, Unisom, Tylenol PM)
  - Antihistamines (i.e. nasal sprays, allergy medications)
- **DO NOT USE ALCOHOL OR 48 hours** before testing
- **AVOID FOOD, TOBACCO & CAFFIENE 4 HOURS PRIOR TO TESTING.** If you are diabetic or prone to lightheadedness, you may have a small meal or juice.
- **DO NOT WEAR EYE MAKEUP**
- **BRING A DRIVER OR ARRANGE TRANSPORTATION** if you have a history of motion intolerance or if you have been diagnosed with benign paroxysmal positioning vertigo (BPPV). The test may leave you with a short-lived feeling of imbalance, and it is helpful to have someone else drive you to and from the test.

Vital medications SHOULD NOT be stopped. Continue to take medications for heart problems, blood pressure, diabetes, thyroid, anticoagulants, anti-seizure or psychiatric medications including anti-depressants, (i.e. Xanax and Elavil), and over the counter pain medications as needed (i.e. Advil, Tylenol) unless otherwise instructed by your primary care physician. If you are unsure about discontinuing a particular medication, please call your primary care physician to determine if it is medically safe for you to be without them for 48 hours. If you have any questions about the test, or about these instructions, please call and talk to your Physician or Audiologist as soon as possible. Please **call 504-568-4348 if you need to reschedule** this test.

What to expect:

Vestibular Assessment aids in the diagnosis and treatment of dizziness and balance problems. There are nearly 90 diseases that cause these symptoms. About one third of these conditions are related to the inner ear and its nerve pathways. Vestibular testing helps identify whether or not an inner ear condition is contributing to your dizziness or balance symptoms.

You may have your hearing tested prior to the vestibular exam. The exam may consist of a hearing test, Videonystagmography(VNG), and/or other various tests of balance function and functional impairment.

Goggles that contain tiny cameras record your eye movements so that the audiologist may evaluate your inner ear and balance system and determine the best treatment plan.

You may resume normal activities after your evaluation. However, driving after the assessment is not advised. After the test, the audiologist will discuss the results and make the appropriate referral to either a neurologist, ENT physician, or physical therapist. The specialty care physician or physical therapist will transmit his/her recommendations to the referring provider.

Case History and Subjective Test Measures

Name:__________________________ **Age:** ________ **Date:**____________

What has been done for your dizziness/imbalance thus far? (Doctors/Medication/Clinics & Dates)

____

____

MEDICAL HISTORY:

- ☐ Circulatory/Vascular
- ☐ Diabetes
- ☐ Stroke/Neurological condition
- ☐ Seizures/Convulsions
- ☐ Loss of consciousness
- ☐ Trauma or Blow to the head
- ☐ Life threatening infection
- ☐ Cancer
- ☐ Cardiac/Heart disease
- ☐ High ☐ Low Blood Pressure
- ☐ Pain in shoulders or neck
- ☐ Tendency to fall
- ☐ Orthopedic conditions: ________________
- ☐ Flu/Virus: (please specify) ________________
- ☐ Cancer ________________
- ☐ Other ________________
- ☐ Ear Infections (please specify):
  ☐ recent ☐ past ☐ childhood
- ☐ Headaches (please specify):
  ☐ recent ☐ past ☐ migraines
- ☐ Vision:
  ☐ Glaucoma
  ☐ Double vision
  ☐ Cataracts – R ☐ Cataracts – L
  ☐ Other: ________________
  Corrected with:
  ☐ Surgery ☐ lenses
- ☐ Dizziness/Vertigo
  ☐ recent ☐ past
  ☐ motion sickness ☐ family
- ☐ Surgeries (please specify):
  ____
  ____
  ____
- ☐ MRSA ☐ VRE
- ☐ Exposure to irritating fumes, paints, etc.

HEARING

Have you had any recent changes in your ears?

Distortion in hearing?	☐ Right	☐ Left	☐ Both
Difficulty hearing?	☐ Right	☐ Left	☐ Both
Pressure/pain in your ears?	☐ Right	☐ Left	☐ Both
Drainage from your ears?	☐ Right	☐ Left	☐ Both
Noise in your ears?	☐ Right	☐ Left	☐ Both
Sensitivity to loud noise?	☐ Right	☐ Left	☐ Both

Describe:____

MEDICATIONS:

Please list current medications:

____

____

Please list any medications you have tried in the past for balance problems:

____

PERSONAL HABITS:

Average hours of sleep each night? ______________________________
Caffeine intake (coffee, tea, soda) ______________________________ cups/ glasses per day
Alcohol intake _________________________ drinks per day
Recreational or illicit drug use __________________________________
Tobacco use __________________________ pack(s) per day
Aerobic exercise ______________________ times per week
Exposure to loud noises? _______________________
Exposure to toxic substances? ___________________

SYMPTOMS:

When did you first notice a problem with your imbalance/dizziness?
____

Please describe your original onset of imbalance/dizziness.
☐ lightheaded ☐ swimmy ☐ disoriented ☐ spinning ☐ tumbling
☐ rocking ☐ tilted ☐ giddy ☐ other ______________________________

Has this changed since the problem began? If so, how would you describe it now?
____

Prior to experiencing these symptoms, what was your level of function?
☐ Independent with all activities
☐ Needed minimal assistance with activities of daily living
☐ Needed moderate assistance to perform activities of daily living
☐ Needed total assistance to perform activities of daily living

Rate your current symptoms (1 = no symptoms, 10 = severe symptoms):
Dizziness (DAS):
No symptoms [☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10] Severe symptoms
Imbalance (DyAS):
No symptoms [☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10] Severe symptoms

Are your symptoms: ☐ Constant ☐ Occurring in attacks ☐ With warning
☐ Comes and goes ☐ Without warning
If you have dizziness/imbalance in between your attacks, describe: _________________________________
When was your last attack/episode? ____
How often do the attacks occur? ____
How long do they last? ☐ < 1 minute ☐ >1 minute ☐ Hours ☐ Days
What makes your symptoms better? ____
What makes your symptoms worse? ____

Have you had difficulty speaking? ☐ Yes ☐ No
Have you had numbness of the hands, feet, mouth, or face? ☐ Yes ☐ No

HEADACHE

Do you have frequent headaches? ________________ How long do your headaches last? ____________
When did you first start getting headaches? _________ Have you been diagnosed with migraine headaches? ___________
Are your headaches associated with nausea/vomiting?___________________________________
How often do you take medication for headaches? (daily/_____ per week/______ per month/ _____)

PREVIOUS TESTING

Audiogram (hearing test)?	☐ Yes	☐ No	☐ Normal	☐ Abnormal
CT Scan?	☐ Yes	☐ No	☐ Normal	☐ Abnormal
MRI?	☐ Yes	☐ No	☐ Normal	☐ Abnormal

DIZZINESS HANDICAP INVENTORY (DHI)

Please **Check** the correct response:

1. I have dizziness/unsteadiness: ☐ 1 per month ☐ > 1 but < 4 per month ☐ more than 1 per week
2. My dizziness/unsteadiness is: ☐ mild ☐ moderate ☐ severe

Instructions: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "YES", "SOMETIMES", or "NO" to each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

Does looking up increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does bending over increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does turning over in bed increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Do you have trouble getting into/out of bed	☐ Yes	☐ Sometimes	☐ No	F
Do they occur in any other positions? (please list) ______________				
Because of your problem do you feel frustrated?	☐ Yes	☐ Sometimes	☐ No	E
Does walking down the aisle of a supermarket increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Do you have difficulty reading?	☐ Yes	☐ Sometimes	☐ No	F
Do quick movements of your head increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Because of your problem is it difficult for you to do strenuous house work or yard work?	☐ Yes	☐ Sometimes	☐ No	F
Is it difficulty for you to walk by yourself?	☐ Yes	☐ Sometimes	☐ No	E
Does going down a sidewalk increase your problem?	☐ Yes	☐ Sometimes	☐ No	P
Is it difficult for you to walk around the house in the dark?	☐ Yes	☐ Sometimes	☐ No	F
Because of your problem,				
Do you feel frustrated?	☐ Yes	☐ Sometimes	☐ No	E
Do you feel handicapped?	☐ Yes	☐ Sometimes	☐ No	E
Are you afraid to leave your home without someone to accompany you?	☐ Yes	☐ Sometimes	☐ No	E
Are you embarrassed in front of others?	☐ Yes	☐ Sometimes	☐ No	E
Are you afraid people may think you are intoxicated?	☐ Yes	☐ Sometimes	☐ No	E
Are you afraid to stay home alone?	☐ Yes	☐ Sometimes	☐ No	E
Are you depressed?	☐ Yes	☐ Sometimes	☐ No	E
Interfere with your household responsibilities or job?	☐ Yes	☐ Sometimes	☐ No	F
Place stress on your relationships with family or friends?	☐ Yes	☐ Sometimes	☐ No	E
Do you avoid heights?	☐ Yes	☐ Sometimes	☐ No	F
Does your problem significantly restrict your participation in social activities such as going out to dinner, going to a movie, dancing, or to parties?	☐ Yes	☐ Sometimes	☐ No	F
Do you restrict your travel for business or recreation?	☐ Yes	☐ Sometimes	☐ No	F

SOCIAL HISTORY:

Occupation: ______________________________

Job responsibilities: ______________________________

With whom do you live? ☐ Alone ☐ Spouse ☐ Other ______________

If you live alone, do you have assistance from anyone? ☐ Yes ☐ No

You require assistance for what activities: ____

Do you use a: ☐ walker ☐ cane ☐ wheelchair

ACTIVITIES SPECIFIC BALANCE CONFIDENCE (ABC) SCALE

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

no confidence **completely confident**

"How confident are you that you will not lose your balance or become unsteady when you….."

1. …walk around the house? ________%
2. …walk up or down the stairs? ________%
3. … bend over and pick up a slipper from the front of a closet floor? ________%
4. …reach for a small can off a shelf at eye level? ________%
5. …stand on your tip toes and reach for something above your head? ________%
6. …stand on a chair and reach for something? ________%
7. …sweep the floor? ________%
8. …walk outside the house to a car parked in the driveway? ________%
9. …get into or out of a car? ________%
10. …walk across a parking lot to the mall? ________%
11. …walk up or down a ramp? ________%
12. …walk in a crowded mall where people rapidly walk past you? ________%
13. …are bumped into by people as you walk through the mall? ________%
14. …step onto or off an escalator while you are holding onto a railing? ________%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ________%
16. …walk outside on icy sidewalks? ________%

Is there anything else that you would like to tell us about your problem today?

____

____

For Clinician Use Only

SCORING

DHI: Total _____/100 F_____/32 E_____/40 P_____/28

DAS: ______/10 DysAS: _____/10