HEARING & BALANCE
DOCTORS

1054 E. Riverside Dr. Suite 201
St. George, UT 84790
Phone: (435) 688-8991

Balance Test

You are scheduled to have a test of your balance system on _____ at _____. The test will take approximately 2 (two) hours. The purpose of this test is to further evaluate complaints of dizziness, poor equilibrium, and certain hearing problems. The test attempts to distinguish the source of your problem; one ear, both ears, the brain, or other parts of the balance system. The test is not painful. However, you may feel dizzy for a short time after the test, so we suggest you arrange for someone to drive you home after the testing is complete.

In order to obtain the most valid, highest quality results from the test, and for your comfort, you are asked to please comply with the following instructions:

1. The following types of medications interfere with the test and should be **discontinued 48 hours prior to the test:**
    a. **Sedatives:** Dalmane, Seconal, Nembutal, Phenobarbital
    b. **Motion Sickness:** Antivert, Dramamine, Meclizine, Bonine
    c. **Antihistamines:** Benadryl, Dimetapp, CIM, Drixoral
    d. **Tranquilizers**: Valium, Traxene, Xanax
    e. Antidepressant Mood Elevators
    f. Sleeping Pills

    Do not discontinue medicines prescribed for heart or lung problems, seizures, diabetes, or blood pressure control. Please call us if you have any questions.

2. Abstain from alcohol and caffeine for **48 hours** before the test. Products containing caffeine include many soft drinks, coffee, tea, cola and chocolate.

3. If medically possible, abstain from food and drink for four (4) hours before the test. If you are a diabetic, or have a similar disorder, eat a light meal and continue your regular routine.

4. You will be asked to remove glasses and/or contact lenses before testing.

5. Do not wear make-up or use facial moisturizers or face creams the day of the test. Wear loose, comfortable clothing and flat-heeled shoes for the test.

There are three forms behind this letter. Please complete the front and back of each form and bring them with you to your appointment. You may contact our office if you have any questions, or if you require additional information about the test by calling us at **(435) 688-8991**; we will be happy to answer any of your questions. If you need to cancel your appointment for any reason, please contact our office **24 hours in advance to avoid a $35 cancellation fee.** We look forward to seeing you! Our office is located at:

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St. George, UT 84790

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Patient Registration

Patient's Name _____ Soc. Sec. # _____-_____-_____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ / _____ /_____ Gender_____ Marital Status _____

Spouse or Relative_____ Relationship _____Phone_____

Referring Physician _____Dr. Phone #_____

Primary Care Physician _____ Dr. Phone # _____

Primary Insurance _____Policy Holder_____ Date of Birth _____

Policy # _____ Group # _____

Secondary Insurance_____ Policy Holder_____ Date of Birth _____

Policy # _____ Group # _____

For patients under 18 years of age

Responsible Party _____ Relationship to Patient _____

Address _____Home Phone _____
Street City State Zip

How did you hear about us? ☐ Friend _____ ☐ Doctor _____
☐ Newspaper ☐ Mail ☐ Phonebook ☐ Seminar ☐ Website ☐ Other_____

Please Initial

_____ I certify this information is true and correct to the best of my knowledge, and I hereby consent to treatment by the providers of Hearing & Balance Doctors of Utah. I understand that diagnostic testing done will be billed to my insurance I have read the terms and conditions of the Billing Agreement and the Notice of Privacy Practices, and hereby agree to abide to all terms and conditions as outlined. I hereby authorize the release of all pertinent information including diagnosis, examination records and treatment records to authorized persons. These records will be held in strict confidence and are not available to unauthorized persons. Hearing and Balance Doctors of Utah may use my home address and/or e-mail address to communicate current and future technology updates and offers related to my treatment.

_____ I understand that Cerumen (wax) removal from the ear canal is not eligible for reimbursement by my insurance. There is a $25 charge per ear for minimal/marginal wax levels, a $50 charge per ear for severe wax levels and a $100 charge per ear for significantly compacted wax levels.

Signed _____ Date _____

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Patient Name _____ Date_____

1. Please describe your symptoms:

2. When did these symptoms begin?

3. Did your symptoms come on □ gradually or □ suddenly?

4. Have symptoms become □ worse (more frequent or more severe) or □ have they improved?

5. Check all that apply to your dizzy spells:

- □ Preceded by flu or cold
- □ Spinning sensation
- □ Falling to one side
- □ Trouble walking in the dark
- □ Comes in attacks
  - How often? _____
  - How long? _____
- □ Free from dizziness between attacks
- □ Nausea
- □ Lightheadedness
- □ Swimming sensation
- □ Dizzier in certain positions
  - Which positions:_____
- □ Dizzy when lying down
- □ Better if you sit or lie perfectly still
- □ Fullness, pressure, or ringing in your ears
- □ Imbalance

6. Check all that apply to other sensations you may have:

- □ Blacking out or fainting when dizzy
- □ Dizzy or unsteady constantly
- □ Severe or recurrent headaches
- □ Double or blurry vision
- □ Numbness in face or extremities
- □ Weakness or clumsiness in arms, legs
- □ Slurred or difficult speech
- □ Difficulty swallowing
- □ Tingling around mouth
- □ Spots before eyes
- □ Jerking of arms and legs
- □ Confusion or memory loss
- □ Dizzy when stand up quickly
- □ Weakness/faintness a few hours after eating

7. Check all that apply to your hearing and circle which ear is affected:

- □ Difficulty hearing Right/Left
- □ Ringing Right/Left
- □ Fullness Right/Left
- □ Pain Right/Left
- □ Discharge Right/Left
- □ Hearing change Right/Left
- □ Exposure to loud noises Right/Left
- □ Previous ear infections Right/Left
- □ Change in hearing when dizzy Right/Left
  - How _____
- □ Previous ear surgery Right/Left
  - When_____
  - What _____

8. Check all that apply to your medical history:

- □ Head injury with loss of consciousness
- □ Allergies
  - Medicines: _____
  - Other: _____
- □ High blood pressure
- □ Low blood pressure
- □ Mental illness
- □ Back or neck injury
- □ Arthritis
- □ Diabetes
- □ Thyroid Disease
- □ Heart Disease
- □ Asthma
- □ Migraine headaches
- □ Stroke
- □ Other: _____

9. Check those that may be linked to your dizziness:

- □ Stress
- □ Menstrual period
- □ Overwork or exertion
- □ Recent change in eyeglass
- □ Headaches
- □ Diet

10. Check all that apply to your habits and lifestyle:

- □ Drink coffee
  How much? _____
- □ Drink tea
  How much? _____
- □ Drink soft drinks?
  How much? _____
- □ Drink alcohol
  How much? _____
- □ Smoke
  How much? _____

11. Please list your current medical problems and length of illness.

12. Please list all surgeries and approximate dates.

13. Please list below, or attach a list, of all medications you currently take, including prescription, over the counter, herbals, vitamins & supplements. If attaching a list, please follow the format shown below.

Medication	**Dosage**	**Frequency**	**Route(ie: oral,injection…)**

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Medications reviewed by: _____ _____
Provider Initials Date

14. Have you had any of the above medicines in the past 48 hours?

15. What studies have been done previously (hearing tests, head scans, blood work, etc.)?

16. Do you have anything else to tell us about your particular problem that we haven't asked you on this questionnaire?

_____ _____
Patient Signature Date

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JACOBSEN DIZZINESS INVENTORY

Patient Name: _____ Date: _____

Instructions: The purpose of this 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 ONLY.** Please circle only one.

Y	S	N	1. Does looking up increase your problem?
Y	S	N	2. Because of your problem, do you feel frustrated?
Y	S	N	3. Because of your problem, do you restrict your recreation/business travel?
Y	S	N	4. Does walking down an aisle of a supermarket increase your problem?
Y	S	N	5. Because of your problem, do you have difficulty getting out of bed?
Y	S	N	6. Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing, or to parties?
Y	S	N	7. Because of your problem, do you have difficulty reading?
Y	S	N	8. Does performing more ambitious activities, like sports, dancing, household chores such as sweeping or putting dishes away, increase your problem?
Y	S	N	9. Because of your problem, are you afraid to leave your home without having someone accompany you?
Y	S	N	10. Because of your problem, have you been embarrassed in front of others?
Y	S	N	11. Do quick movements of your head increase your problems?
Y	S	N	12. Because of your problem, do you avoid heights?
Y	S	N	13. Does turning over in bed increase your problem?
Y	S	N	14. Because of your problem, is it difficult for you to do strenuous housework or yard work?
Y	S	N	15. Because of your problem, are you afraid people may think you are intoxicated?
Y	S	N	16. Because of your problem, is it difficult for you to walk alone?

PLEASE TURN OVER AND COMPLETE THE REVERSE SIDE

Y S N 17. Does walking down a sidewalk increase your problem?

Y S N 18. Because of your problem, is it difficult for you to concentrate?

Y S N 19. Because of your problem, is it difficult for you to walk around your house in the dark?

Y S N 20. Because of your problem, are you afraid to stay home alone?

Y S N 21. Because of your problem, do you feel handicapped?

Y S N 22. Has your problem placed stress on your relationships with members of your family or friends?

Y S N 23. Because of your problem, are you depressed?

Y S N 24. Does your problem interfere with your job or household responsibilities?

Y S N 25. Does bending over increase your problem?

Please mark an "X" on the line corresponding to how intense or how severe the following symptoms are for you at this time. This line represents a number line from 0-10, 0 representing no problem and 10 representing it could not be worse.

How much of a problem or how much is your instability or balance interfering in completing your daily routines?

0----------10

How severe is your dizziness and how much is dizziness interfering with you completing your daily life routines?

0----------10

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JDI Score: _____

Dizziness Score: _____

Balance Score: _____