South Location
5255 E. Stop 11 Road, Suite 405
Indianapolis, IN 46237
Phone: 317-807-0744
Fax: 317-807-1359

The Center for Equilibrium Disorders
BalancePoint
A Division of Otolaryngology Associates
www.balancepointindy.com

North Location
12188B North Meridian Street
Check-In Suite 230
Carmel, IN 46032
Phone: 317-807-0744
Fax: 317-807-1359

Pre-Appointment Packet

Your doctor has recommended a Balance Assessment to help determine the cause of your symptoms of dizziness, motion sickness, and/or unsteadiness. The findings will help guide your doctor in choosing the best form of treatment. Testing is scheduled for two hours, though may be shorter. If you have had balance testing elsewhere within the past year, please bring copies of the test results with you. We will look at these results and decide if any of the tests do not need to be repeated.

Instructions for Vestibular Testing

- Please do not wear makeup **(especially eye makeup)**.
- For VNG and rotary chair testing, if you are already unsteady we suggest you bring someone with you that can drive you home after the testing is completed.
- Please do not eat anything 3 hours before testing. If you are diabetic or need to eat near testing time, please eat a small snack.
- **Please bring a list of the medications you are taking.**
- We ask that you **avoid** the following for 24 hours prior to testing:
  - alcohol
  - dizziness, nausea or motion sickness medications
  - cold medicines and antihistamines
  - sleeping pills, sedatives, or tranquilizers (unless you have been on these for at least 8 weeks)
- **Please continue taking all essential medications. These include heart and blood pressure medication, seizure medication, diabetes medicine, and psychiatric medicines.**

Description of Vestibular Testing

The following are a list of tests that may be completed at your appointment:

VNG: This test shows us whether both inner ears of balance are equally strong. We will ask you to follow moving lights with your eyes. We will have you lay down on a table the same way you would in bed. Lastly, we will gently flow warm or cool water in your ears and record your eye movements.

Rotary Chair Test: For this test, you will sit in a chair and we will record your eye movements as the chair slowly moves back and forth in a dark room.

VEMP: The VEMP test provides us with information about how the balance parts of the inner ear called the saccule and utricle are functioning. We will have you lay down on a table and lift your head up while a sound is played in your ear.. We will also have you look upwards when you hear the sound.

EcochG: This test evaluates for excessive fluid pressure in the inner ear. We will place earphones in your ears through which you will hear clicking sounds. Sticker electrodes will be placed on your head. You will lay relaxed with your eyes closed for the test.

Hearing Evaluation: This test evaluates your hearing in each ear to determine if there is a reduction in your hearing range. This takes place in a sound-treated booth and measures your hearing sensitivity for different pitches (frequencies). Speech perception tests will be completed to help determine your ability to hear and understand words without using visual cues.

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Cancellation Policy: Due to the large block of time needed for testing, patients who fail to show for their scheduled appointment or do not notify the office within 24 hours of their scheduled appointment time will be charged a $100 fee. These fees are not covered by insurance and is therefore the sole responsibility of the patient and/or guardian.

If it is necessary to cancel your appointment, we require you call one working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely testing. Please call our office at 317-807-0744.

Payment Policy: While the filing of insurance claims is a courtesy that we extend to our patients, **you are personally responsible for knowing your policy benefits and any amount not covered by your insurance.**

If you have concerns about whether your insurance company will pay for these tests, it is your responsibility to contact them. To assist you with this, we have listed all the CPT procedure codes used in the balance assessment below. The insurance company will need these codes to answer your questions.

CPT Code	Description	Number of Units Tested
92557	Comprehensive Hearing Evaluation	1
92567	Tympanometry	1
92540	Comprehensive Vestibular Exam	1
92537/92538	Caloric Vestibular	1
92546	Sinusoidal Rotation	1
92584	Electrocochleography	1
92517 / 92518	Unspecified Otolaryngology Procedure- VEMP test	1

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Please bring the following completed paperwork in order to be evaluated in a timely fashion.

Name: _____ DOB: _____

Dizziness Questionnaire (Furman, Cass, & Whitney 2010)

Characteristics of Dizziness

Is your dizziness associated with any of the following sensations? Please read the entire list first, then circle yes or no to describe your feelings most accurately.

Yes	No	1.	Lightheadedness or swimming sensation in head		
Yes	No	2.	Blacking out or loss of consciousness		
Yes	No	3.	Tendency to fall		
Yes	No	4.	Objects spinning or turning around you		
Yes	No	5.	Sensation that you are turning or spinning inside, with outside objects remaining stationary		
Yes	No	6.	Loss of balance when walking in the light:	Veering to the Right?	Left?
Yes	No	7.	Loss of balance when walking in the dark:	Veering to the Right?	Left?
Yes	No	8.	Headache		
Yes	No	9.	Nausea		
Yes	No	10.	Vomiting		
Yes	No	11.	Pressure in the head		
Yes	No	12.	Tingling in the fingers or toes		
Yes	No	13.	Tingling around the mouth		

Associated Ear Symptoms

Do you have any of the following symptoms? Please circle yes or no and circle the ear involved, if applicable.

Yes	No	1.	Dizziness. Please describe dizziness. _____			
			_____			
Yes	No	2.	Difficulty in hearing?	Both Ears	Right	Left
Yes	No	3.	Does your hearing change with dizziness? If so, how? _____			
			_____			
Yes	No	4.	Do you have noise in your ears?	Both Ears	Right	Left
Yes	No	5.	Does noise change with dizziness? If so, how? _____			
			_____			
Yes	No	6.	Do you have fullness or stuffiness in your ears?	Both Ears	Right	Left
Yes	No	7.	Do you have pain in your ears?	Both Ears	Right	Left
Yes	No	8.	Do you have a discharge from your ears?	Both Ears	Right	Left

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Time Course and Aggravating Factors

1. When did your dizziness first occur? _____
2. How often do you become dizzy? _____
3. If dizziness occurs in attacks, how long does an attack last? _____

Yes No 4. Do you have any warning that dizziness is about to start?
Yes No 5. Does dizziness occur at any particular time of the day or night?
Yes No 6. Are you completely free of dizziness between attacks?
Yes No 7. Does change of position make you dizzy? Which movements? _____
Yes No 8. Do you become dizzy when rolling over in bed? To the right? To the left?
Yes No 9. Do you know of any possible cause for your dizziness? What? _____

Yes No 10. Do you know of anything that will:
a. Stop your dizziness or make it better? _____
b. Make your dizziness worse? _____
Yes No 11. Do you become dizzy when you bend your head forward? Backward?
Yes No 12. Do you become dizzy when you cough?
Yes No When you sneeze?
Yes No When you have a bowel movement?
13. Can any of the following make your dizziness worse or start an attack?
Yes No Fatigue?
Yes No Exertion?
Yes No Hunger?
Yes No Menstrual period?
Yes No Emotional upset?
Yes No Alcohol?
Yes No 14. Do you have any allergies? What? _____

Associated Neurologic Symptoms

Have you experienced any of the following symptoms? Please circle yes or no and circle if constant or in episodes.

Yes	No	1.	Double vision	Constant	In Spells
Yes	No	2.	Blurred vision	Constant	In Spells
Yes	No	3.	Blindness	Constant	In Spells
Yes	No	4.	Numbness of the face or extremities	Constant	In Spells
Yes	No	5.	Weakness in the arms or legs	Constant	In Spells
Yes	No	6.	Confusion or loss of consciousness	Constant	In Spells
Yes	No	7.	Difficulty with speech	Constant	In Spells
Yes	No	8.	Difficulty with swallowing	Constant	In Spells
Yes	No	9.	Pain in the neck or shoulders	Constant	In Spells

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Past Medical History, Family History, Social History

Yes No 1. Did you have a history of earaches or ear infections as a child?

Yes No 2. Did you ever injure your head? When? _____

Yes No 3. Were you ever unconscious? When? _____

Yes No 4. Did you suffer from motion sickness before the age of 12?

Yes No 5. Have you suffered from motion sickness in the last 10 years?

Yes No 6. Do you now take any medications regularly? What? _____

_____

Yes No 7. Have you taken medications in the past for dizziness? Which ones? _____

_____

8. Do you have a past medical history of:

Yes No Diabetes?

Yes No Heart disease?

Yes No High blood pressure?

Yes No Kidney disease?

Yes No Migraine headache?

Yes No Thyroid disease?

9. Do you have a family history of:

Yes No Ear disease?

Yes No Neurologic disease?

Yes No Migraine headache?

Yes No 10. Do you use tobacco in any form? What kind? _____ How much? _____

Yes No 11. Does caffeine affect your dizziness? How? _____

Yes No 12. Does alcohol affect your dizziness? How? _____