



*** IMPORTANT INFORMATION CONCERNING YOUR TESTING ***

Patients are responsible for bringing a prescription from their physician stating “Consult to Audiology”. Failure to do so at the time of testing may result in rescheduling.

If you need to cancel or reschedule please do so at least 48 hours prior to your visit to be courteous to other patients who are waiting for appointments to become available. Cancellations less than 48 hours in advance of appointment may incur fees.

1. MEDICATIONS

DO NOT TAKE: 24 hours before testing

- tranquilizers, sleeping pills, drugs for dizziness or for allergies.
- Alcohol

CONTINUE TAKING:

- medications for conditions such as: diabetes, heart disease, high blood pressure, or seizure

Note: consult your prescribing physician if you are unsure about discontinuing any medications.

2. DIET – avoid / limit caffeine

- DIABETIC PATIENTS - eat as usual
- ALL Others - observe a light diet for 3 hours before testing.

3. CLOTHING

- Wear pants, socks, and comfortable loose fitting clothing
- Do NOT wear any makeup (including eye liner and mascara), perfumes, or cologne

4. GENERAL

- Arrive 30 minutes before your appointment for parking, check-in and registration.
- Bring your completed Balance Center questionnaire with you.
- You may feel dizzy after testing. Bringing someone with you to drive is advisable.
- Results will be forwarded to your referring physician within one week.

DESCRIPTION OF BALANCE TESTS

Information from your eyes, feet, and balance organs in your ears help you keep your balance. Balance tests help your doctor determine what part(s) of the balance system may be causing your symptoms. The tests are painless, but some of them may make you feel unsteady, dizzy, or occasionally nauseated for a few minutes. This does not happen to every patient, and most patients do not have any trouble with the testing. If you have bothersome symptoms during testing, we will give you a break to recover.

The typical balance study lasts two hours. You will take one or more of the following tests:

- Hearing Testing: (Billing Codes: 92557, 92550).
- You will watch moving lights while we record your eye movements. You will be asked to move into various positions while lying on a bed. For the final part of the test, the examiner will put warm and/or cool water into your outer ear while you are lying down. This is not painful, but may make you feel lightheaded or dizzy for a brief period. (Billing Codes: 92540, 92541, 92542, 92537, 92538, 92545 - - one or more may be used based on testing performed).
- You may stand on a platform that tells us how much you sway. The platform moves back and forth slightly at times during the test. The examiner will explain what will happen before each set of movements. You will be wearing a safety harness so that you cannot fall. (Billing Code: 92548). ***In the event that this procedure is not covered by your insurance you will be billed \$50.00.***
- You may be sitting in the dark for a short time, in a chair, which moves in a gentle, side-to-side motion. During this test, the examiner will be talking with you and observing your eye movement on camera. (Billing Code: 92546).

Division of Audiology

<http://pennhealth.com/ent/services/audiology.html>

Appointments:

Phone: (215) 662-2784 or email: audiology@uphs.upenn.edu



Department of Otorhinolaryngology:
Head & Neck Surgery

Division of Audiology

South Pavilion Expansion, 3rd Floor

BALANCE CENTER QUESTIONNAIRE

DATE:

NAME:

MRN:

DOB:

In order to fully evaluate your complaints, please complete all questions, bring this survey, and bring a prescription from your physician stating "Consult to Audiology" when you return for your balance function testing. Failure to do so at the time of testing may result in cancellation or rescheduling.

1. Describe symptoms / complaints in detail:

2. When did symptoms begin:

3. How long do symptoms last: seconds minutes hours days

4. How often do symptoms occur:: constant daily weekly monthly yearly
(never stop) times times times times

5. Symptoms occur when: walking standing sitting laying any time

Do you have:

	No	Yes	During Spells
Imbalance / unsteadiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of falling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinning / tumbling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rocking / swaying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Blacking Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jumping Vision (while walking / riding)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

additional comments:

Are symptoms worsened by:

Lying down or rolling over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting or standing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking in darkness / uneven surfaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot baths / showers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading / Computer Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loud Noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing, Sneezing, Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head turns while walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supermarkets, malls, tunnels, bridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automobile rides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Ears / Eyes:	No	Right	Left
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus (ringing, buzzing, other noises)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perforated / Torn Eardrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (eg. blind, lazy, or eye disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DATE:
NAME:
DOB:

Headache History:	No	Yes		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
How often do they occur		<input type="checkbox"/> daily	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
How long do they last		<input type="checkbox"/> minutes	<input type="checkbox"/> hours	<input type="checkbox"/> days
Migraine Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>		
With nausea vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
Caused by certain food / drink	<input type="checkbox"/>	<input type="checkbox"/>		
Family history of migraine	<input type="checkbox"/>	<input type="checkbox"/>		
Related to menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>		
Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>		

Past Medical History: Please describe and list dates.

Head or Neck Conditions requiring medical care: select all that apply...

	No	Yes
Motor Vehicle Accident	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Skull Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Brain Surgery	<input type="checkbox"/>	<input type="checkbox"/>

Chronic Medical Conditions: select all that apply	No	Yes
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic Disorders (MS, Parkinson's, other)	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Depression, Anxiety, or other Psychiatric Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Spine, lower limb, or other skeletal Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Neuropathy (numbness / tingling)	<input type="checkbox"/>	<input type="checkbox"/>

Medical Treatments: select all that apply...	No	Yes
Intravenous antibiotics (-mycin drugs)	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>

Medications	No	Yes
Anti-dizzy or motion sickness medications	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives / Sleep Medications	<input type="checkbox"/>	<input type="checkbox"/>
Heart Medications	<input type="checkbox"/>	<input type="checkbox"/>
Depression, Anxiety, or other Psychiatric Medications	<input type="checkbox"/>	<input type="checkbox"/>