Adventist Health Balance and Mobility Center
10201 SE Main Street Suite 4
Portland OR 97216
(503) 251-6350

For office use only
Appointment Date:_____
Insurance:_____

TIME IN:_____
TIME OUT:_____

Patient Questionaire

Instructions: Please complete the questions as best as you can and bring with you on the day of your appointment. The information will assist us in making your appointment as effective as possible. If you would like to return it ahead of time, please mail it to the address listed above.

Personal Information:

Date form was completed: _____
Name:_____
Address:_____
_____
Home phone:_____
Date of Birth:_____
Occupation:_____
Primary Care Physician:_____
Address:_____
Phone:_____
Referring Physician:_____
Address:_____
Phone:_____

The Problem……

Briefly state the problem for which you are seeking help:

When did your symptoms or similar symptoms FIRST begin (no matter how long ago)?

Describe in as much detail as you can what happened (use back if need more room):
_____
_____
_____
_____
_____
_____
_____
_____

(Description of first symptoms, continued…)

Do you ever have symptoms occur when you are sitting, standing, or lying completely still, NOT having just moved and NOT watching anything that is moving? YES NO

If yes, check all symptoms that occur in this spontaneous manner:

Off balance
Lightheaded or fainting sensation
Tumbling or spinning sensation

Do you ever have symptoms that are brought on by you making a movement or a change in position? YES NO

If yes, check all symptoms that occur with you movements or position changes:

Off balance
Lightheaded or fainting sensation
Tumbling or spinning sensation

Are your symptoms made worse by any of the following? (Check all that apply)

Lying down / rolling in bed
Walking in the dark
Hot baths or showers
Menstrual cycle
Automobile rides
Loud sounds
Sitting up / Standing up
Walking on uneven surfaces
Coughing / sneezing / nose blowing
Supermarket aisles / malls / tunnels
Windshield wipers
Restaurants or g0.0003 Tcr-I

Hearing……

Check all of the following that apply to you:

I think I have a hearing loss, but this is not confirmed by testing.
I have a documented hearing loss:
- In my left ear
- In my right ear
- In both ears

My hearing changes from day to day (good some days, worse others)
I have ringing or noise that I hear:
- In my left ear
- In my right ear
- In both ears
- all the time
- only in quiet
- off and on

I have pain in my ear(s): What rating would you give the pain in your ear(s) on a scale from 1-10 (1 little pain; 10 horrible pain)
- In my left ear
- In my right ear
- In both ears
- all the time
- off and on

I have frequent infections/drainage from my ear(s):
- In my left ear
- In my right ear
- In both ears
- all the time
- off and on

Other disorders……

Do you currently have or have you been diagnosed in the past with any of the following?

Stroke	Brain or Spinal cord disorder	Blood disease
Heart problems	High blood pressure	Seizures
Cancer	Anxiety / depression / panic	Glaucoma
Diabetes	6(What1ent Tc0 Tw5	555555 11.4 0000000000000000000

Social and Family History……

Please check all that <u>apply to you</u>:

I smoke
I drink beverages with caffeine
I drink alcoholic beverages
I live alone
I have a history of use of “recreational drugs”
I have repeated direct exposure to loud noises
…….. to toxic items

Please check all that <u>apply to your family members</u>: (please write in who has these symptoms)

Dizziness	Imbalance and/or falling	Headaches
Diabetes	Heart disease	Stroke
Hearing loss	High blood pressure	Anxiety

Medications……

Please attach or list below a COMPLETE LI

COMPUTERIZED DYNAMIC POSTUROGRAPHY

Computerized Dynamic Posturography (CDP) Assesment of balance function under differing conditions and identification of patterns that aid in diagnosis. Your brain receives balance and orientation information from three systems: eyes, inner ear, and body. This test helps us pinpoint which information pathway is in error or missing by systematically eliminating each one. The test is approximately 25 minutes in length.

CDP is a three-part evaluation. You will be secured into a vest/harness and then asked to stand on a platform. The CDP evaluates body sway, center of gravity and the ability to compensate for motion.

YOU SHOULD NOT POSTPONE THIS TEST IF YOU ARE SYMPTOMATIC.

To prepare for the test, **you must avoid** all generic and herbal versions of the medications listed below for 48 hours prior to testing:

Antihisamines:	**Chlortrimeton, Benedryl, Dimatane**
Dizziness:	**Antivert, Dramamine, Meclizine, Marezine, Bonine, Scopolamine, Phenergran**
Sedatives:	**Dalmane, Seconal, Nembutal, Phenobarbital**
Tranquilizers:	**Valium, Librium, Tranxene, Meprobamate, Ativan, Xanax**

<u>DO NOT</u>: DISCONTINUE MEDICATIONS THAT HAVE BEEN PRESCRIBED FOR DIABETES, HEART CONDITIONS, SEIZURES, OR BLOOD PRESSURE.

<u>AVOID</u> CAFFEINE, ALCOLHOL AND SMOKING FOR 24 HOURS PRIOR TO TESTING.

<u>WOMEN</u> PLEASE WEAR SLACKS.

I have read and understand the above contents and agree to the test ordered.

Signed_____ Date_____

VIDEONYSTAGMOGRAPHY

Videonystagmography (VNG) helps determine if there are problems with the balance system within the inner ear. A disorder of the balance mechanism results in small eye jerks (nystagmus) which are picked up by an infrared camera that is attached to a set of goggles. The VNG test is a four-part evaluation. which records eye jerks or nystagmus. The first series of tasks consists of looking back and forth at different points and tracking moving lights. The second part requires you to shake your head. The third part consists of lying down and sitting up quickly and lying in different positions. The last portion of the test requires putting cool and warm air into the ear canal for approximately 40 seconds to determine if the balance mechanism increases and decreases normally in the response to temperature stimulation. This portion of the test often causes you to feel as if you are spinning for approximately 2-5 minutes. This is a common reaction. If you have concerns regarding residual dizziness please make arrangements for someone to transport you. The test will take approximately one hour.

Preparing for the evaluation:

- **You must avoid** all generic and herbal versions of the medications listed below for **at least 48 hours** prior to testing:

Antihisamines: **Chlortrimeton, Benedryl, Dimatane**
Dizziness: **Antivert, Dramamine, Meclizine, Marezine, Bonine, Scopolamine, Phenergran**
Sedatives: **Dalmane, Seconal, Nembutal, Phenobarbital**
Tranquilizers: **Valium, Librium, Tranxene, Meprobamate, Ativan, Xanax**

- **Do not drink coffee, tea, soda or any beverage containing caffeine or alcohol for at least 24 hours prior to testing.**
- **Eat lightly on the day of the test.**
- **Women please do not wear <u>mascara or eyeliner</u> on the day of testing. The camera used to record eye movements is sensitive to dark eye makeup.**

DO NOT DISCONTINUE MEDICATIONS THAT HAVE BEEN PRESCRIBED FOR DIABETES, HEART CONDITIONS, SEIZURES, OR BLOOD PRESSURE.

I have read and understand the above contents and agree to the test ordered.

Signed_____Date_____