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Balance & Vestibular Evaluations

The balance system detects position and movement of the head in relation to gravity, relaying signals from the eyes, bones and joints to the brain and nervous system to maintain equilibrium. When these signals are disrupted, balance disorders can result.

What are Balance Disorders?

A balance disorder is defined as any condition that causes you to feel dizzy or unsteady. Two of the most common examples are dizziness and vertigo.

Dizziness is characterized by a feeling of lightheadedness, causing many patients to feel as though they are going to faint. This may be accompanied by nausea, disorientation, confusion and a sensation of floating.

Vertigo is the feeling that your environment is moving around you, and is frequently described as a spinning sensation. Symptoms include nausea, vomiting, double vision, tinnitus, fullness in the ear and hearing loss.

Each condition may be caused by a variety of factors. Dizziness often occurs in response to a sudden drop in blood pressure, such as that experienced when standing up quickly after being seated for a while. Ear infections, neurological disorders, inner ear abnormalities, anemia and other conditions can trigger dizziness. Vertigo typically occurs due to false signals being transmitted from the vestibular system to the brain, a result of factors such as calcium crystals "floating" in the inner ear, inflammation of the inner ear, benign tumors on the vestibular nerve, an inner ear disorder called Meniere's disease that causes excess fluid accumulation or other types of vestibular dysfunction.

Treating Dizziness & Vertigo

Patients experiencing sensations of dizziness, lightheadedness or vertigo will undergo balance testing in order to determine the cause of their symptoms.

Treatment will vary depending on the condition. Solutions might involve medications such as antihistamines, sedatives or antibiotics; surgery; physical therapy; vestibular rehabilitation exercises; and/or lifestyle modifications including dietary changes and refraining from smoking.

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Dizziness/Balance Evaluation Patient Instructions

You are scheduled for a test of your balance system. There are a few things you should know prior to your appointment.

MEDICATIONS

Certain medications affect the test results. Below is a partial list of medications that should not be taken for 48 hours prior to the test. Ask your doctor if you have concerns about discontinuing your medications. The list below is a partial list with generic name first and trademark name bolded in parenthesis.

- **Alcohol** - beer, wine, liquor, cough medicine
- **Medications commonly used to reduce dizziness and nausea** - Meclizine **(Antivert, Bonnine, Ru-Vert-M),** Hydroxyzine **(Atarax, Vistaril),** Lorazepam **(Ativan),** Diphenhydramine **(Benadryl)**, Prochlorperazine **(Compazine),** Dimenhydrinate **(Dramamine)**, Clonazepam **(Klonipin),** Cyclizine **(Marezine),** Promethazine **(Phenergan),** Trimethobenzamine **(Tigan),** Diazepam **(Valium),** Nearly all motion sickness patches or medications.

OTHER MEDICATIONS

- **Analgesics/Narcotics** - Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet
- **Anti-histamines** - Fexofenadine **(Allegra),** Loratadine **(Claritin, Alavert),** Chlorpheniramine **(Chlor-Trimeton, Efidac, Teldrin),** Brompheniramine **(Dimetane),** Clemastine **(Tavist),** Cetirizine **(Zyrtec),** nearly all-over-the-counter allergy or flu/cold medicines
- **Sedatives** - Flurazepam **(Dalmane),** Triazolam **(Halcion),** Pentobarbital **(Nembutal),** Temazepam **(Restoril),** Secobarbital **(Seconal),** among others.
- **Tranquilizers/Anti-anxiety medications** - Chlordiazepoxide hydrochloride and clidinium bromide **(Librax),** Chlordiazepoxide hydrochloride **(Librium),** Oxazepam **(Serax),** Clorazepate **(Tranxene),** Alprazolam **(Xanax)**. Any pill given for insomnia or anxiety can alter results by making you drowsy/lethargic.

You may take blood pressure medications, heart medications, thyroid medications, Tylenol, insulin and estrogen. Always consult with your doctor before discontinuing any prescribed medications.

OTHER LIMITATIONS

- NO caffeine (coffee, soda, tea, etc.) for 4 HOURS before the test
- NO smoking for 4 HOURS before the test
- NO eating for 2 HOURS before the test, this meal should be a light meal

FOR YOUR COMFORT AND CONVENIENCE

Dress comfortably; part of the test requires lying down.

DO NOT wear makeup, mascara, liner, etc., as it will interfere with the exam. The exam looks at eye movements that are produced by your sensation of dizziness. The exam will not proceed if you wear makeup.

ABOUT THE TESTING

A comprehensive battery of tests will be performed during the approximately 2-hour appointment allocated for you. The tests are simple and painless. One or two of the tests may cause a sensation of motion that may linger. If possible, we encourage you to have someone with you for driving purposes. If this is not possible, plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

Once your testing is completed, the battery of exams is carefully analyzed and reviewed. This process is as important as your testing, so please understand that your tests results will not be discussed in detail with you until several days after your visit. Following the interpretation of the testing, you will receive a phone call to review your results with your audiologist. A detailed report will also be sent to your referring physician regarding our conclusions and recommendations. If there is a need for balance exercises/rehabilitation beyond what we may offer, we will provide the names of physical therapists experienced in working with patients suffering from balance disorders. Please contact our office if you have any further questions or concerns. We look forward to your visit.

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Dizziness Handicap* Inventory

Patient Name _____ Date _____ DOB _____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please check Yes, No, or Sometimes (S) for each question. Answer each question as it pertains to your dizziness or unsteadiness only.

P1	Does looking up increase your problem?	☐ Yes	☐ Sometimes	☐ No
E2	Because of your problem, do you feel frustrated?	☐ Yes	☐ Sometimes	☐ No
F3	Because of your problem, do you restrict your travel for business or recreation?	☐ Yes	☐ Sometimes	☐ No
P4	Does walking down the aisle of a supermarket increase your problem?	☐ Yes	☐ Sometimes	☐ No
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐ Yes	☐ Sometimes	☐ No
F6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties?	☐ Yes	☐ Sometimes	☐ No
F7	Because of your problem, do you have difficulty reading?	☐ Yes	☐ Sometimes	☐ No
P8	Does performing more ambitious activities like sports, or dancing or household chores such as sweeping or putting dishes away increase your problem?	☐ Yes	☐ Sometimes	☐ No
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐ Yes	☐ Sometimes	☐ No
E10	Because of your problem, are you embarrassed in-front of others?	☐ Yes	☐ Sometimes	☐ No
P11	Do quick movements of your head increase your problems?	☐ Yes	☐ Sometimes	☐ No
F12	Because of your problem, do you avoid heights?	☐ Yes	☐ Sometimes	☐ No
P13	Does turning over in bed increase your problem?	☐ Yes	☐ Sometimes	☐ No
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐ Yes	☐ Sometimes	☐ No

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E15	Because of your problem, are you afraid people might think you are intoxicated?	☐ Yes	☐ Sometimes	☐ No
F16	Because of your problem, is it difficult for you to walk by yourself?	☐ Yes	☐ Sometimes	☐ No
P17	Does walking down a sidewalk increase your problem?	☐ Yes	☐ Sometimes	☐ No
E18	Because of your problem, is it difficult for you to concentrate?	☐ Yes	☐ Sometimes	☐ No
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐ Yes	☐ Sometimes	☐ No
E20	Because of your problem, are you afraid to stay home alone?	☐ Yes	☐ Sometimes	☐ No
E21	Because of your problem, do you feel handicapped?	☐ Yes	☐ Sometimes	☐ No
E22	Has your problem placed stress on your relationship with members of your family or friends?	☐ Yes	☐ Sometimes	☐ No
E23	Because of your problem, are you depressed?	☐ Yes	☐ Sometimes	☐ No
F24	Does your problem interfere with your job or household responsibilities?	☐ Yes	☐ Sometimes	☐ No
P25	Does bending over increase your problem?	☐ Yes	☐ Sometimes	☐ No
	Total:	_____	_____	_____

Total: _____ _____ F _____ E _____ P
(36) (36) (28)

From Jacobson, G.P., and Newman, C.W. "The development of the dizziness handicap inventory," Arch. Otolaryngol. Head Neck Surg. 1990; 116 (4): 424

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Audiology Medical History

Patient Name _____ Date _____ DOB _____

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

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

II. Characterize your dizziness:
Please tell us about the specifics of your dizziness:

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

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10	Do you know of anything that will: a. Stop your dizziness or make it better? _____ _____ b. Make your dizziness worse? _____ _____			
11	Do you become dizzy when you bend your head? ☐ Forwards? ☐ Backwards?	☐ Yes	☐ Sometimes	☐ No
12	a) Do you become dizzy when you cough? b) When you sneeze? c) When you have a bowel movement?	☐ Yes ☐ Yes ☐ Yes	☐ Sometimes ☐ Sometimes ☐ Sometimes	☐ No ☐ No ☐ No
13	Can any of the following make your dizziness worse or start an attack? a) Fatigue b) Extertion c) Hunger d) Menstrual period e) Stress f) Emotional upset g) Alcohol	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ Sometimes ☐ Sometimes ☐ Sometimes ☐ Sometimes ☐ Sometimes ☐ Sometimes ☐ Sometimes	☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No
14	Do you have any allergies? To what? _____	☐ Yes	☐ Sometimes	☐ No

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

1	Difficulty in hearing? ☐ Both Ears ☐ Right ☐ Left	☐ Yes	☐ Sometimes	☐ No
2	Does your hearing change when you are dizzy? If so, how? _____	☐ Yes	☐ Sometimes	☐ No
3	Do you have sounds in your ears? ☐ Both Ears ☐ Right ☐ Left Describe the sound: _____	☐ Yes	☐ Sometimes	☐ No
4	Does the sound change when you are dizzy? If so, how? _____	☐ Yes	☐ Sometimes	☐ No
5	Do you have fullness/stuffiness in your ears? ☐ Both Ears ☐ Right ☐ Left	☐ Yes	☐ Sometimes	☐ No
6	Do you have pain in your ears? ☐ Both Ears ☐ Right ☐ Left	☐ Yes	☐ Sometimes	☐ No

IV. Have you experienced any of the following symptoms?
Please check Yes or No and check if constant or in episodes.

1	Double Vision ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
2	Blurred Vision ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
3	Blindness ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
4	Numbness of the face or extremities ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No

5	Weakness in the arms or legs ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
6	Clumsiness of the arms or legs ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
7	Confusion or loss of consciousness ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
8	Difficulty with speech ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
9	Difficulty with swallowing ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No
10	Pain in the neck or shoulders ☐ Constant ☐ In Episodes	☐ Yes	☐ Sometimes	☐ No

V. Past medical history:

1	Did you have a history of earaches or ear infections as a child?	☐ Yes	☐ Sometimes	☐ No
2	Did you ever injure your head? When? _____	☐ Yes	☐ Sometimes	☐ No
3	Were you ever unconscious? When? _____	☐ Yes	☐ Sometimes	☐ No
4	Did you suffer from motion sickness before age 12?	☐ Yes	☐ Sometimes	☐ No
5	Have you suffered from motion sickness in the last 10 years?	☐ Yes	☐ Sometimes	☐ No
6	Do you take any medications regularly? What? _____ _____	☐ Yes	☐ Sometimes	☐ No
7	Have you taken medication for dizziness in the past? Which ones? _____ _____	☐ Yes	☐ Sometimes	☐ No
8	a) Do you have a medical history of Diabetes? b) Heart disease? c) Kidney disease? d) Thyroid disease? e) Migraines?	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No ☐ No	
9	Do you have a family history of: a) Ear disease? b) Neurologic disease? c) Migraine headache?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No	
10	Do you use tobacco in any form? What kind? _____ How Much? _____	☐ Yes	☐ Sometimes	☐ No
11	Does caffeine affect your dizziness? How? _____	☐ Yes	☐ Sometimes	☐ No
12	Does alcohol affect your dizziness? How? _____	☐ Yes	☐ Sometimes	☐ No

* From Furman, J.M., Cass, S.P. and Whitney, S.L. Vestibular Disorders, ed 3 New York: Oxford University Press, 2010.