Penn Medicine
at the Perelman Center for Advanced Medicine

The Balance Center (215) 662-2784
South Pavilion Expansion, 3rd Floor
Division of Audiology / Dept. of Otorhinolaryngology

* 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 or 92549). 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).

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Department of Otorhinolaryngology:
Head & Neck Surgery

Division of Audiology
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BALANCE CENTER QUESTIONNAIRE

DATE:

NAME:

MRN:

DOB:

In order to fully evaluate your complaints, please complete <u>all</u> 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 *(never stop)* ☐ daily __ *times* ☐ weekly __ *times* ☐ monthly __ *times* ☐ yearly __ *times*

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

Do you have:	**No**	**Yes**	**During Spells**	*additional comments:*
Imbalance / unsteadiness	☐	☐	☐	
History of falling	☐	☐	☐	
Spinning / tumbling	☐	☐	☐	
Rocking / swaying	☐	☐	☐	
Lightheadedness	☐	☐	☐	
Fainting / Blacking Out	☐	☐	☐	
Nausea / vomiting	☐	☐	☐	
Double Vision	☐	☐	☐	
Jumping Vision (while walking / riding)	☐	☐	☐	
Are symptoms worsened by:				
Lying down or rolling over	☐	☐	☐	
Sitting or standing up	☐	☐	☐	
Walking in darkness / uneven surfaces	☐	☐	☐	
Hot baths / showers	☐	☐	☐	
Menstrual Cycle	☐	☐	☐	
Exercise	☐	☐	☐	
Reading / Computer Work	☐	☐	☐	
Loud Noises	☐	☐	☐	
Coughing, Sneezing, Straining	☐	☐	☐	
Head turns while walking	☐	☐	☐	
Supermarkets, malls, tunnels, bridges	☐	☐	☐	
Automobile rides	☐	☐	☐	

DATE:

NAME:

DOB:

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

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

Past Medical History: *Please describe and list dates.*

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

	No	**Yes**
Motor Vehicle Accident	☐	☐
Whiplash	☐	☐
Concussion	☐	☐
Skull Fracture	☐	☐
Brain Surgery	☐	☐

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

Medical Treatments: *select all that apply…*	**No**	**Yes**
Intravenous antibiotics (-mycin drugs)	☐	☐
Chemotherapy	☐	☐
Radiation therapy	☐	☐

Medications	**No**	**Yes**
Anti-dizzy or motion sickness medications	☐	☐
Sedatives / Sleep Medications	☐	☐
Heart Medications	☐	☐
Depression, Anxiety, or other Psychiatric Medications	☐	☐