HEARING HEALTH CENTER
Earning your trust since 1984

Main Office	Fox Run Square	Oakbrook Mall	Highland Park	Resurrection Medical Ctr.
142 E. Ontario St.	1212 S. Naper Blvd.	120 Oakbrook Ctr.	185 Skokie Valley Rd.	7447 W. Talcott Ave.
Suite 1100	Suite 103	Suite 709	Crossroads Shopping Ctr.	Suite 360
Chicago, IL 60611	Naperville, IL 60540	Oak Brook, IL 60523	Highland Park, IL 60035	Chicago, IL 60631
312.263.7171	630.369.8878	630.571.7111	847.681.7000	773.466.8878

THE CENTER FOR BALANCE DISORDERS

YOUR APPOINTMENT IS SCHEDULED FOR:

DAY:_____ DATE:_____ TIME:_____

LOCATION: ____ CHICAGO 312.263.7171 ____ NAPERVILLE 630.369.8878

Please contact us if you are unable to keep your appointment, and we will be happy to reschedule it for you. There is a **$75.00** charge for appointments not canceled with 24-hour notice. If you have any questions or concerns regarding the test, please call.

PATIENT INFORMATION AND INSTRUCTIONS FOR ENG AND VNG

1. TEST PROCEDURE: This is a test of the balance portion of the inner ear.
2. MEDICATIONS: Many commonly-used medications may affect test results, except heart, blood-pressure and cholesterol medications. **If you have questions about whether a certain medication you are taking should be stopped, please inform the audiologist as soon as possible before your test date.**
    a. **DO NOT TAKE ANTIVERT (MECLIZINE), DRAMAMINE, BENADRYL, BONINE, VALIUM OR LIBRIUM FOR 48 HOURS PRIOR TO TESTING.**
    b. **DO NOT TAKE ANY SEDATIVES, TRANQUILIZERS, ANTIHISTAMINES (ALLERGY MEDICATIONS) OR STIMULANTS FOR 48 HOURS PRIOR TO TESTING.**
    c. **ANY ALCHOL MUST BE AVOIDED FOR 48 HOURS PRIOR TO TESTING.**
    d. **AVOID COFFEE, TEA, CAFFEINE OR TOBACCO FOR 24 HOURS PRIOR TO TESTING.**
3. MEALS: Please refrain from eating for at least 2 hours before your test unless medically necessary. A bland, light snack is recommended if necessary.
4. MAKE-UP: Electrodes may be taped to your forehead, cheek and beside each eye. Please do not use any makeup or lotions on your face on the day of the test.
5. GLASSES: Please bring your glasses or contact lenses with you on the test day.
6. AFTER THE TEST: You may feel tired, dizzy or off-balance for several hours. It is recommended that a friend or family member drive you home from the test

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Patient Information

First Name:_____Middle Initial:_____Last Name:_____

Address:_____Unit #:_____

City:_____State:_____Zip:_____

Sex: M F Birthdate:_____

Employment Status: ☐ Retired ☐ Full Time ☐ Part Time ☐ Student

Occupation/Former Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

How did you hear about us? _____

Contact Information

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email:_____

Preferred method of contact: ☐ Email ☐ Home ☐ Work ☐ Cell

Emergency Contact:_____ Relation: _____ Phone:_____

Insurance Information

Primary Insurance: _____ Secondary Insurance _____

Name of Insured: _____ Relation to Patient: _____ DOB:_____

Primary Care Physician: _____ Phone #: _____

Address: _____ City: _____ State/Zip: _____

Health History

List all medications and reason for taking:_____

_____

_____

What brings you in today?_____

When was your last hearing test? _____

Have you ever been treated for hearing loss?_____

Financial Responsibility and Consent

I agree to be responsible for all charges incurred. I agree that visits may be recorded aurally for internal training purposes.
Authorization to Release Information: I hereby authorize release of any medical information necessary in the course of treatment.

SIGNATURE _____ DATE _____

DIZZINESS QUESTIONNAIRE

Name:_____ Age:_____ Sex:_____ Date:_____

The following questions refer to your feelings of dizziness. Please answer them "yes" or "no" and fill in all of the blanks.

1. **Please describe, in your own words, the sensation you feel without using the word "dizzy."**

   _____

   _____

2. **Do you ever have any of the following sensations?**

   YES___ NO___ Spinning in circles?
   YES___ NO___ Objects spin or turn around you with your eyes opened?
   YES___ NO___ Objects spin or turn around you with your eyes closed?
   YES___ NO___ Do you feel lightheaded when you are dizzy?
   YES___ NO___ Do you feel a swimming sensation when you are dizzy?
   YES___ NO___ Do you black out or faint when you are dizzy?
   YES___ NO___ Do you have severe or recurrent headaches?
   YES___ NO___ Do you have double or blurry vision?
   YES___ NO___ Do you have spots before your eyes?
   YES___ NO___ Do you have difficulty swallowing?
   YES___ NO___ Do you have weakness in your arms or legs?
   YES___ NO___ Do you have tingling around your mouth?
   YES___ NO___ Do you have numbness in your face or extremities?
   YES___ NO___ Do you have slurred or difficult speech?
   YES___ NO___ Do you have confusion or memory loss?

3. **The following refer to a typical dizzy spell:**

   YES___ NO___ Do the dizzy spells come in attacks?
   When did the dizziness first occur? _____
   How often do they occur? _____
   How long do they last? _____
   YES___ NO___ Are you free from dizziness between attacks?
   YES___ NO___ Is the dizziness worse when you are in certain positions?
   Which positions? _____
   YES___ NO___ Are you nauseated during an attack?
   YES___ NO___ Are you dizzy when lying down?
   YES___ NO___ Do you feel better if you sit or lie perfectly still?
   YES___ NO___ Do you have trouble walking in the dark?
   YES___ NO___ Has a cold or flu preceded recent dizzy spells?
   If so, when were you sick?_____

4. **The following refer to your hearing:**

   YES___ NO___ Have you noticed any change in your hearing?
   YES___ NO___ Do you have difficulty hearing? Right _____ Left_____ Both_____
   YES___ NO___ Do you have ringing in your ears? Right _____ Left_____ Both_____
   YES___ NO___ Do you have fullness in your ears? Right _____ Left_____ Both_____

YES___ NO___ Does your hearing change when you are dizzy?
How? _____
YES___ NO___ Are you exposed to loud noise?
YES___ NO___ Have you ever been exposed to loud noise?
YES___ NO___ Have you ever had ear infections?
When? _____
How often? _____
YES___ NO___ Have you ever had ear surgery?
What kind? _____
When? _____
YES___ NO___ Does anyone in your family have hearing loss?
Who? _____
YES___ NO___ Do you have pain in your ear(s)? Right _____ Left_____ Both_____
YES___ NO___ Do you have discharge from your ear(s)? Right ___ Left___ Both____

5. **The following refer to habits and lifestyle:**

YES___ NO___ Do you drink coffee? How much? _____
YES___ NO___ Do you drink tea? How much? _____
YES___ NO___ Do you drink soda? How much? _____
YES___ NO___ Do you drink alcohol? How much? _____
YES___ NO___ Do you smoke? How much? _____
YES___ NO___ Did you recently change eyeglasses?
YES___ NO___ Is your dizziness related to moments of stress?
YES___ NO___ Is your dizziness related to your menstrual period?
YES___ NO___ Is your dizziness related to overwork or exertion?
YES___ NO___ Do you breathe faster or deeper when excited or dizzy?

6. **Miscellaneous:**

YES___ NO___ Are you allergic to any medications?
What? _____
YES___ NO___ Are you allergic to anything else?
What? _____
YES___ NO___ Are you dizzy when you sit or stand up quickly?
YES___ NO___ Do you get weak or dizzy a few hours after eating?
YES___ NO___ Do you have high blood pressure?
YES___ NO___ Do you have low blood pressure?
YES___ NO___ Do you have diabetes?
YES___ NO___ Do you have low blood sugar?
YES___ NO___ Do you have thyroid disease?
YES___ NO___ Do you have asthma?
YES___ NO___ Have you had cancer? When? _____

7. Has there been anything recently that has added stress to your life?

_____

_____

8. Please list any current medical problems and length of illness.

_____
_____
_____

9. Please list all surgeries performed and approximate dates.

_____
_____

10. Please list all medications you currently take. Include all pain medicines, sleeping pills, birth control pills, and non-prescription medicines.

_____
_____

11. What studies/tests have been performed previously? (E.g. hearing, balance, radiographs, scans)

_____
_____

12. Do you have anything to add about your particular problem that we haven't asked you on this questionnaire?

_____
_____
_____

Patient signature: _____ Date: _____

DIZZINESS HANDICAP INDEX

Name: _____ **Date:** _____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question by writing the corresponding letter in the blanks on the right side of the paper. *Answer each question as it pertains to your dizziness or unsteadiness only.*

Y = Yes **S = Sometimes** **N = No**

	Your Answer:	**Office Use Only**
1. Does looking up increase your problem?	_____	P _____
2. Because of your problem do you feel frustrated?	_____	E _____
3. Because of your problem do you restrict your travel for business and/or recreation?	_____	F _____
4. Does walking down the aisle of a supermarket increase your problem?	_____	P _____
5. Because of your problems do you have difficulty getting into or out of bed?	_____	F _____
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing, or parties?	_____	F _____
7. Because of your problem do you have difficulty reading?	_____	F _____
8. Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting away dishes away increase your problem?	_____	P _____
9. Because of your problems are you afraid to leave your home without having someone accompany you?	_____	E _____
10. Because of your problem have you been embarrassed in front of others?	_____	E _____
11. Do quick movements of your head increase your problem?	_____	P _____
12. Because of your problem do you avoid heights?	_____	F _____
13. Does turning over in bed increase your problem?	_____	P _____
14. Because of your problem is it difficult for you to do strenuous housework or yard work?	_____	F _____
15. Because of your problem are you afraid people may think you are intoxicated?	_____	E _____
16. Because of your problem is it difficult for you to walk by yourself?	_____	F _____
17. Does walking down a sidewalk increase your problem?	_____	P _____
18. Because of your problem is it difficult for you to concentrate?	_____	E _____
19. Because of your problem is it difficult for you to walk around your house in the dark?	_____	F _____
20. Because of your problem are you afraid to stay home alone?	_____	E _____
21. Because of your problem do you feel handicapped?	_____	E _____
22. Has your problem placed stress on your relationships with members of your family?	_____	E _____
23. Because of your problem are you depressed?	_____	E _____
24. Does your problem interfere with your job or household responsibilities?	_____	F _____
25. Does bending over increase your problem?	_____	P _____

For Office Use Only:

Functional _____(36) Emotional _____(36) Physical _____(28) TOTAL _____(100)

PATIENT NAME:_____ **DATE:**_____

THE ACTIVITIES-SPECIFIC BALANCE CONFIDENCE SCALE (ABC)

For each of the following, please indicate your level of confidence in doing the activities without losing your balance or becoming unsteady by choosing one of the percentage points on the scale from 0% to 100%. If you do not currently do these activities in question, try to imagine how confident you would be if you had to do these activities. If you normally use a walking aid to do the activities or hold on to someone, rate your confidence as if you were using these supports. If you have any questions about answering any of these things, ask the administrator.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Confidence **Completely Confident**

How confident are you that you will not lose your balance or become unsteady when you…….

1. Walk around the house?_____%
2. Walk up or down the stairs?_____%
3. Bend over and pick up a slipper from the front of a closet floor?_____%
4. Reach for a small can off the shelf at eye level?_____%
5. Stand on your tiptoes and reach for something above your head?_____%
6. Sweep the floor?_____%
7. Walk outside of the house to a parked car in the driveway?_____%
8. Stand on a chair and reach for something?_____%
9. Get in or out of a car? _____%
10. Walk across the parking lot to the mall?_____%
11. Walk up or down a ramp?_____%
12. Walk in a crowded mall where people rapidly walk past you?_____%
13. Are bumped into by people as you walk through the mall?_____%
14. Step on or off an escalator while you are holding onto a rail?_____%
15. Step onto or off an escalator while holding onto parcels such that you cannot hold on to the railing?_____%
16. Walk outside on a wet or slippery sidewalk?_____%

SCORE:_____