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…)

When did you last notice your symptoms?

How do you feel today (please answer on day of appointment)?

Have your symptoms changed since they first began? YES NO

If yes, in what way have they changed?

Are your symptoms with you 24 hours per day never stopping? YES NO

If yes, check all symptoms that are present 24 hours per day never stopping:

- □ Off balance when standing or walking
- □ Off balance when sitting or lying down
- □ Lightheaded or fainting sensation
- □ Tumbling or spinning sensation

Do you have symptoms that occur in spells? YES NO

If yes, check all symptoms that occur in spells (no matter how long the spell):

- □ Off balance when standing or walking
- □ Off balance when sitting or lying down
- □ Lightheaded or fainting sensation
- □ Tumbling or spinning sensation

Check the one that, on the average, describes how long the symptoms last:

- □ Measured in seconds
- □ Measured in minutes to hours but less than 24 hours
- □ Measured in hours to days but less than 7 days
- □ Measured in days, can last continuously for weeks

Check the one that, on the average, describes how frequently your symptoms occur:

- □ Daily or multiple times per day
- □ Multiple times per week
- □ Multiple times per month
- □ Several times in a 2-month interval
- □ Several times in a 6-month interval
- □ Several times in a 12-month interval

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
- Reading
- Exercise
- Sitting up / Standing up
- Walking on uneven surfaces
- Coughing / sneezing / nose blowing
- Supermarket aisles / malls / tunnels
- Windshield wipers
- Restaurants or movie theaters
- Turning your head when walking
- Reaching or bending

ASSOCIATED SYMPTOMS AND PROBLEMS

Check all the following symptoms that you have experienced:

- Unexplained falls
- Sensation of being pulled or pushed down
- Loss of consciousness (blacked out)
- Nausea and/or vomiting
- Double vision (side by side or up down)
- Vision “jumping” when walking or riding
- Heart racing
- Panic feeling – sudden need to leave a place

Circle the above symptoms that occurred with dizziness/imbalance

THE NEXT PAGE DEALS WITH HEADACHES. COMPLETE THE QUESTIONS AS INDICATED EVEN IF YOU DO NOT FEEL HEADACHES ARE A CONCERN.

Headaches……..

Have you had a total of 5 or more headaches (no matter how severe) in your lifetime?
YES NO

Have you ever had a headache that was severe enough to make you stop your activity and sit or lie down? YES NO

Have you ever experienced a temporary change in your vision, such as jagged lines, color spots or lightening bolts? YES NO

Have you ever experienced a loss of vision in one or both eyes? YES NO

If you answered <u>NO to all three questions</u> above, please skip to the section on HEARING.

If you answered <u>YES to any</u> of the three questions above, please continue with the next questions:

Please check all of the following that you have experienced:

- Headaches where the discomfort localizes to a region(s) of the head
- Increased sensitivity to light during a headache
- Increased sensitivity to sound during a headache
- Increased sensitivity to odors during a headache
- A headache provoked by a sudden bright light, such as sunlight
- Increased chance of headache around menstral cycle (females only)
- Change in headache behavior with pregnancy or after
- Certain foods or beverages increase the chances of a headache
- Motion sickness as a young child prior to puberty
- Nausea and/or vomiting with a headache
- Headache that lasted longer than 24 hours
- Headaches associated with your problems of dizziness or imbalance
- Headaches where the pain throbs or pulses

If having headaches, at what age do you first remember having a headache?

- Under age 12
- In your teens
- 20’s or 30’s
- In your 40’s
- In your 50’s
- In your 60’s, 70’s or 80’s

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
- □ Heart problems
- □ Cancer
- □ Diabetes
- □ Loss of taste
- □ Loss of smell
- □ Joint disease
- □ Sexual dysfunction
- □ Brain or Spinal cord disorder
- □ High blood pressure
- □ Anxiety / depression / panic
- □ Memory problems
- □ Significant weight changes
- □ Ongoing stomach problems
- □ Ongoing breathing problems
- □ Ongoing Numbness or tingling
- □ Blood disease
- □ Seizures
- □ Glaucoma
- □ Cataracts
- □ Autoimmune disorder

Hospitalizations and injuries……

Have you been in the hospital for or had any of the following injuries?

- ☐ Hospitalized for treatment of an infection with antibiotic therapy
- ☐ Surgery on either ear
- ☐ Surgery on either eye
- ☐ Eye injury
- ☐ Ear injury
- ☐ Automobile accident
- ☐ Surgery on brain or spinal cord
- ☐ Surgery on hips / knees / ankles
- ☐ Head or neck injury
- ☐ Broken back / hip / knee / ankle
- ☐ Other_____

OTHER MEDICAL AND SOCIAL HISTORY

Please indicate what tests you have had for your problem. Check all that apply:

Test	Normal	Abnormal	Don't know
Hearing test (Audiogram)	☐	☐	☐
MRI of brain with injection	☐	☐	☐
MRI of brain without injection	☐	☐	☐
MRI of neck or back	☐	☐	☐
ENG/VNG (water/air in ear)	☐	☐	☐
ECoG (Electrocochleography)	☐	☐	☐
EEG (Brain wave test)	☐	☐	☐
ABR (Auditory Brainstem test)	☐	☐	☐
Tilt table test (for fainting)	☐	☐	☐
Rotational chair test	☐	☐	☐
Spinal tap (Lumbar puncture)	☐	☐	☐
Posturography (Standing balance)	☐	☐	☐
Doppler / Ultrasound blood flow	☐	☐	☐
MRA of head/neck blood flow	☐	☐	☐
Blood test for syphilis	☐	☐	☐
Blood test for Lyme disease	☐	☐	☐
Blood test for Thyroid function	☐	☐	☐
Blood test for HIV	☐	☐	☐
Blood test for CBC, electrolytes, etc	☐	☐	☐
Other_____	☐	☐	☐

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 LIST of (1) current prescription and over-the-counter medications you are taking and (2) medications you have tried in the past for your symptoms.

Medication: Dosage: For what condition:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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_____