Dr. Rodriguez
Audiology & Hearing Center
1000 w 4th st. (575)-623-8474 Fax (575) 623-8220

Balance Testing Instructions

Your appointment for balance testing has been scheduled for
_____at_____am.

Please follow these instructions exactly.

If necessary please bring a translator to your appointment.

IT IS VERY IMPORTANT THAT YOU HAVE SOMEBODY DRIVE YOU TO AND FROM THIS APPOINTMENT.

IF YOU DO NOT SHOW UP FOR YOUR APPOINTMENT WITHOUT 24 HOUR PRIOR NOTICE, YOU WILL NOT BE RESCHEDULED.

You must complete these forms and bring them with you to your appointment. Do not mail them to us. Do not drop them off at the office. If you do not have the forms completed at the time of your appointment you may need to reschedule.

Certain medications must be avoided for 48 hours before the test, including:
sleeping pills diuretics tranquilizers sedatives antihistamines
muscle relaxants anti-dizzy medications barbiturates anti-depressants
anti-anxiety medications pain medication.

**Please do not discontinue prescription medications without checking with the physician who prescribed them. If you cannot go without a medication listed above, please call our office to discuss this prior to arriving for the evaluation.

You may continue to take medication for thyroid, heart, diabetes, blood pressure, cholesterol and respiratory disorders. If you have any doubt about which medications you should not take, ask your doctor if any will affect the central nervous system.

- **Do not drink** coffee, coke, tea, alcohol beverage, or other stimulants (caffeine drinks) **24 hours** before your test.
- **Do not use tobacco** in any form **24 hours** prior.
- **Do not eat 4 hours** prior to your test.
- Do not wear makeup, including mascara.
- Wear comfortable clothes.

We will test your balance with three types of procedures.

1. Following a moving dot of light with your eyes.
2. Turning your head or body in different positions.
3. Irrigating your ears with warm water and then with cool water.

Eye movement is recorded with a video camera attached to a pair of goggles.

The procedure takes 1 ½ - 2 hours and is simple and painless. Your test results will be sent to your referring/ordering physician.

We look forward to seeing you. Please call (575) 623-8474 if you have any questions

Dizziness Study

Patient Name: _____DOB: _____

PLEASE ANSWER ALL QUESTIONS

When did your dizziness first occur? Date: _____

When you are "dizzy," do you experience any of the following sensations?

Please Circle Yes or No

- Lightheadedness Yes No
- Swimming sensation in the head Yes No
- Blacking out Yes No
- Loss of consciousness Yes No
- Tendency to fall Yes No
- Fall to the right Yes No
- Fall to the left Yes No
- Fall forward Yes No
- Fall backward Yes No
- Objects spinning or turning around you Yes No
- Sensation that you are turning or spinning inside, with outside objects remaining stationary Yes No
- Loss of balance when walking Yes No
- Veering to the right Yes No
- Veering to the left Yes No
- Headache Yes No
- Nausea or vomiting Yes No
- Pressure in the head Yes No

Please circle Yes or No, and fill in the blank if applicable.

- My dizziness is constant Yes No
- My dizziness is in attacks Yes No

If yes, how often? FREQUENT / MODERATE / SELDOM / UNSURE

Most recent episode? Date: _____

How long do your attacks last? WEEKS / DAYS / HOURS / MINUTES / SECOND

Dizziness Study Continued

- Can you tell when an attack is about to start? Yes No
- Are you completely free of dizziness between attacks? Yes No
- Does change of position make you dizzy? Yes No
- Do you have trouble walking in the dark? Yes No
- When you are dizzy, can you stand unsupported? Yes No
- Do you know of any possible cause of your dizziness? Yes No

If yes, explain: _____

- Do you know of anything that will stop your dizziness or make it better? Yes No

If yes, explain: _____

- Do you know of anything that will make your dizziness worse? Yes No

If yes, explain: _____

- Do you know of anything that will trigger an attack of dizziness? Yes No

If yes, explain: _____

- Were you exposed to any fumes, paints, etc. at the onset of your dizziness? Yes No
- Do you have any allergies? Yes No
- Did you ever injure your head? Yes No
  If yes, explain:_____
- Were you unconscious? Yes No

Do you have any of the following symptoms? Circle Yes or No, and circle either ear involved.

- Difficulty in hearing Yes No Right / Left / Both
- Noise in your ears Yes No Right / Left / Both
  Describe the noise: RINGING / HISSING / STATIC / OTHER _____

Does the noise change with dizziness? Yes No

If yes, explain: _____

- Fullness or stiffness in your ears? Yes No Right / Left / Both
- Pain in your ears? Yes No Right / Left / Both
- Discharge or drainage from your ears? Yes No Right / Left / Both

Dizziness Study Continued

Have you experienced any of the following symptoms? Circle Yes or No, and circle either constant or in episodes.

- Double Vision Yes No Constant Episodes
- Numbness of face or extremities Yes No Constant Episodes
- Blurred vision or blindness Yes No Constant Episodes
- Weakness in arms or legs Yes No Constant Episodes
- Clumsiness in arms or legs Yes No Constant Episodes
- Confusion Yes No Constant Episodes
- Loss of consciousness Yes No Constant Episodes
- Difficulty with speech Yes No Constant Episodes
- Difficulty when swallowing Yes No Constant Episodes

Do you have any family members with hearing disorders? Yes No

If yes, explain: _____

Please check if you have family members with any of the following:

Heart Disease____ Thyroid Disorder____ Diabetes____ Hardening of the arteries ____

Please check if *YOU* have any of the following:

Heart Disease____ Thyroid Disorder____ Diabetes____ Hardening of the arteries ____

Does anyone else in your family have dizziness problems? Yes No

If yes, explain: _____