Washington University in St. Louis

SCHOOL OF MEDICINE

Department of Otolaryngology-Head and Neck Surgery
Dizziness and Balance Center

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Medical Director

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APPOINTMENT: ____________________________ TIME: ___________

Dear Patient:

Thank you for scheduling an appointment in the Dizziness and Balance Center located at the Center for Advanced Medicine. We have written this letter to help assist you with your visit with us.

Please come to the Ear, Nose, and Throat Center on the 11th floor, Suite A of the Center for Advanced Medicine located at 4921 Parkview Place. You should plan to arrive 15 minutes before your scheduled appointment time. For your convenience, we have enclosed a map and directions. Please complete and bring all the papers that are enclosed in this packet as well as your insurance card. Certain insurance programs require a referral, if necessary, please arrange for a referral to have vestibular testing BEFORE your appointment. Payment is due at the time of service based on your insurance plan. Please check with your insurance company before your visit to inquire as to your responsibility.

Enclosed you will find instructions for preparing for your testing. Please call with any questions regarding the instructions. Adherence to these instructions is important or it may be necessary to reschedule your testing. You are encouraged to bring someone with you in the event you do not feel comfortable driving home after your testing. Time needed for testing depends on which tests your doctor has ordered and varies.

In addition, we will validate your parking garage ticket for 50% of your parking fee. Please bring your ticket with you. If you have any questions please call our office at (314) 362-7509 or toll free (800) 437-5430. We look forward to your visit.

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Washington University School of Medicine at Washington University Medical Center, Campus Box 8115, Department of Otolaryngology, 660 South Euclid Avenue, St. Louis, MO 63110, Patient Care (314) 362-7509, Fax (314)747-5593 http://oto.wustl.edu

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INSTRUCTIONS

1. Please plan to arrive at the Center for Advanced Medicine building 15 minutes prior to your appointment. See the enclosed map for parking directions.
2. Enclosed is a medical record release authorization form. Please sign the release form in the event pertinent medical records from your physician are needed in order to assist us in evaluating your condition.
3. Enclosed is a questionnaire, registration and fee form. Please complete and bring them with you the day of your appointment.
4. Please fill out the attached questionnaire **prior** to arriving for your appointment.
5. Certain substances influence the body's response to the tests. Therefore, for **48 hours** prior to your appointment we ask that you do not take any of the following: caffeine (coffee, soft drinks, and tea), alcoholic beverages, medication for control of dizziness or nausea, tranquilizers, sleeping pills, cold remedies, or aspirin. If pain medication is needed, acetaminophen (Tylenol) may be substituted until the testing has been completed. Please call with any questions regarding medications.

   *****PLEASE CONTINUE TAKING ANY LIFE SUSTAINING MEDICATIONS SUCH AS INSULIN, BLOOD PRESSURE, HEART, AND ANY OTHER ROUTINE MEDICATIONS*****
6. Please refrain from food and drink for **4 hours** prior to the test. If you are a diabetic, please make sure that you eat a snack and/or bring one with you for immediately following the test.
7. Please refrain from tobacco for **4 hours** prior to the test.
8. Please refrain from wearing make-up (especially eyeliner and mascara).
9. Wear loose fitting clothing for your test, which entails a variety of head and body motions and positions. Ladies please wear slacks.

TEST PROCEDURES INCLUDE ALL OR SOME OF THE FOLLOWING:

Following with your eyes various stationary or moving lights

Placing you in various head and body positions to assess if these maneuvers elicit symptoms of dizziness.

Passing warm and cool water through a small balloon or directly placed in your ear canals.

Placing you in a standing position on a special scale-like platform to test steadiness.

Rotating you back and forth on a special motorized chair.

Placing electrodes on the surface of your skin and recording muscle activity while you listen to a clicking sound.

A VARIETY OF EYE, HEAD, AND BODY MOVEMENT WILL BE RECORDED DURING THESE PROCEDURES. THE DEVICES USED TO MEASURE THESE MOVEMENTS ARE SIMILAR TO GOGGLES. THERE IS A CAMERA MOUNTED INSIDE THE GOGGLES AND IS NOT DANGEROUS OR PAINFUL.

Dept. Otolaryngology-Head and Neck Surgery
Dizziness and Balance Center

You have been referred to the Dizziness and Balance Center by your doctor for specialized balance testing. You are scheduled for one or more of the tests listed below.

1) VIDEO-OCULOGRAPHY (VOG) (includes calorics) – tests eye movement which is controlled by the inner ear, the brain, or both.
2) Calorics ONLY – tests eye movement controlled by one part of the inner ear in each ear independently.
3) VIDEO HEAD IMPULSE TEST (vHIT) – tests an inner ear/eye reflex with fast head movements.
4) ROTARY CHAIR – tests the inner ear reflex over a wide range of movement.
5) DYNAMIC SUBJECTIVE VISUAL VERTICAL (DSVV) –tests a specific portion of the inner ear for control of balance.
6) VESTIBULAR EVOKED MYOGENIC POTENTIALS (VEMP)-tests a separate and specific portion of the inner ear.
7) COMPUTERIZED DYNAMIC POSTUROGRAPHY (EQUITEST/PLATFORM)- tests the ability to use vision, inner ear, and musculo-skeletal system information to maintain balance.

These charges will be precertified by our staff and you will be notified of their approval or otherwise prior to your visit. After your visit, they will be submitted to your insurance carrier for consideration of reimbursement. If, however, for any reason your insurance does not cover these procedures you will be expected to pay for them directly. These tests take significant time and effort and have been requested by your physician for your benefit.

If you wish to proceed with testing, please sign and date this form. Thank you for your cooperation.

"I have read the above information and agree to be responsible for charges associated with any test/procedure not covered by my insurance."

NAME:________________________________**DATE:**________________

Revised 3-15

Dept. Otolaryngology-Head and Neck Surgery
Dizziness and Balance Center

MEDICAL RELEASE FORM

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

JOEL A. GOEBEL, M.D.
WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
DEPARTMENT OF OTOLARYNGOLOGY
DIZZINESS AND BALANCE CENTER
660 SOUTH EUCLID
CAMPUS BOX 8115
ST. LOUIS, MO 63110
FAX (314) 747-5593

A complete copy of my medical records as indicated below. I specifically authorize the release of information pertaining to any head or body trauma, antibiotic history, psychiatric history, and drug and/or alcohol abuse, if such is a part of my medical history. This consent may be revoked in writing at any time.

____________Medical Records

____________X-ray films including X-ray reports

____________Records of medications given to the patient.

NAME OF PATIENT (Please print):__________________________________

ADDRESS:____

BIRTHDATE:_______________________________________

SOCIAL SECURITY NUMBER:__________________________

PATIENT OR AUTHORIZING SIGNATURE:____

DATE:__________________

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Name: ___________________________D.O.B.____________

Please describe in your own words, the sensation you feel without using the word "dizzy":
____
____

Please circle the symptom that brought you here today:

Spinning in circles   Falling to one side   World spinning around me

Please circle:

YES NO My dizzy spells come in attacks

Date of first attack: ___________________

How often: _________________________

How long is the attack:________________

YES NO I am dizzier in certain positions

Which position: _______________________________

YES NO I am free from dizziness between attacks
YES NO My hearing changes with an attack
YES NO I am dizzy if I stand up quickly
YES NO I am nauseated during an attack
YES NO I have had a recent cold or flu
YES NO I have had fullness, pressure, or ringing in my ears
YES NO I have had pain or discharge in my ears
YES NO I have trouble walking in the dark
YES NO I am better if I sit or lie perfectly still
YES NO Loud sounds make me dizzy

YES NO I black out or faint when dizzy
YES NO I have severe or recurrent headaches
YES NO I am sensitive to light during my headaches and/or dizziness
YES NO I have double or blurry vision
YES NO I have numbness in my face or extremities
YES NO I have weakness or clumsiness in my arms/legs
YES NO I have slurred or difficult speech
YES NO I have difficulty swallowing
YES NO I have tingling around my mouth
YES NO I see spots before my eyes
YES NO I have jerking of my arms/legs
YES NO I have seizures
YES NO I have confusion or memory loss
YES NO I have had recent head trauma

The following refer to your hearing. Indicate which side has been affected:

YES	NO	I have difficulty hearing	Left	Right	Both
YES	NO	I have ringing	Left	Right	Both
YES	NO	I have fullness	Left	Right	Both
YES	NO	I have a change	Left	Right	Both

Have you had any of the following:

YES	NO	Pain in ears	Left	Right	Both
YES	NO	Discharge in ears	Left	Right	Both
YES	NO	Exposure to loud noise	Left	Right	Both
YES	NO	Ear infections	Left	Right	Both
YES	NO	Trauma to ears	Left	Right	Both
YES	NO	Previous ear surgery	Left	Right	Both
		Describe: ____			
YES	NO	I have a family history of deafness	Left	Right	Both

The following refer to habits and lifestyle:

YES NO There is added stress to my life recently
YES NO I am dizzy or unsteady constantly
My dizziness is related to:
YES NO Moments of stress
YES NO Menstrual period
YES NO Overwork or exertion
YES NO I feel lightheaded or "swimming" sensation when I am dizzy
YES NO I breathe faster or deeper when excited or dizzy
YES NO I recently changed eyeglasses
YES NO I feel weak or faint a few hours after eating
YES NO I drink coffee
How much ____________
YES NO I drink tea
How much ____________
YES NO I drink soft drinks
How much ____________
YES NO I drink alcohol
How much ____________
YES NO I smoke
What _______How much ________
YES NO I previously smoked
What _______How much ________

MEDICAL HISTORY:

Please list your current medical problems and length of illness: ________________________
____
____

Please list all surgery performed and approximate date: ______________________________
____
____

Please list all allergies (including drugs) and reaction: ________________________________
____
____

Please list all medications you currently take (including over the counter meds):__________
____
____

Please list previous testing (hearing, x-rays, head scans, etc):__________________________
____
____

FAMILY HISTORY: (Please specify relationship to you)

YES NO Migraine ____________________
YES NO High blood pressure ____________________
YES NO Low blood pressure ______________________
YES NO Diabetes ______________________
YES NO Low blood sugar __________________________
YES NO Thyroid disease ________________________
YES NO Asthma _________________________
YES NO Other diseases______________________
____

SYSTEM REVIEW:

Circle all symptoms you currently experience:

Constitutional:
Recent weight change
Fever
Fatigue

Eyes:
loss of vision
Pain
Discharge/tearing

Ear, Nose, Mouth, Throat:

Itchy ears	Nasal obstruction	Drooling
Nosebleed	Sneezing	Stuffy nose
Loss of sense of smell	Growth in nose	Bleeding from throat
Mouth growth, ulcer	Chewing difficulty	Lump in neck
Pain on swallowing	Heartburn	Sore throat
Voice changes	Breathing difficulty	Nasal discharge
Facial weakness	Snoring	Dental problems

Cardiovascular:
- Chest pain
- Irregular heart beat
- Swelling of legs
- Leg pain with walking
- Leg pain with rest

Respiratory:
- Wheezing
- Cough
- Shortness of breath
- Mucous
- Coughing up blood

Gastrointestinal:
- Decrease in appetite
- Diarrhea/Constipation
- Nausea/Vomiting
- Indigestion
- Blood in stool
- Food intolerance

Musculoskeletal:
- Neck pain
- Joint pain/Stiffness
- Arthritis
  - name joint(s) ___________________

Skin:
- Rash
- Jaundice
- Recent Baldness

Neurological:
- Headache
- Tremor
- Blackout
- Seizures
- Paralysis

Psychiatric:
- Insomnia
- Depression

Endocrine:
- Thyroid trouble
- Heat/Cold intolerance
- Excessive sweating
- Excessive thirst, hunger, urination

Genitourinary:
- Painful urination
- Difficulty passing urine
- Venereal disease
- Incontinence
- Blood in urine
- Frequent urination at night

Hematologic/Lymphatic:
- Bleeding problems
- Anemia
- Easy bruising
- Blood disorder

Do you have anything else to tell us about your problem that we have not asked on this questionnaire?

____

____

_____________________________________ _________________

Provider Signature **Date**

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