Vestibular Assessment

You have been scheduled for a TWO-hour test. Please, if you cannot make the appointment call our office at least 24 hours ahead of time to reschedule.

Dear Patient:

Thank you for choosing our clinic. Please read and complete all information in this packet prior to your appointment scheduled for _____ at _____.

You have been scheduled for dizziness or balance testing. The testing will take about two hours. Testing is painless, but you may feel dizzy or nauseated for some time after the appointment. For this reason, we recommend that you arrange for someone to drive you home following your appointment.

Dizziness and balance testing is generally divided into three parts. For all procedures, you will have electrodes taped to your face so we can measure your eye movements. First, you will be asked to watch a series of lights on the wall. Second, you will be asked to move your head and body into several different positions. Finally, we will introduce warm and cool air into your ear canal.

Please note, certain medications may change the findings of the examination. We ask that you do not take any nonessential medications for a period of 48 hours before your appointment time, and that you especially avoid the following:

- Any anti-dizzy pills
- Sleeping pills
- Tranquilizers
- Antihistamines
- Narcotics of any kind
- Over-the-counter cold or allergy medications
- Medications that contain any of the above
- Alcoholic beverages

DO NOT discontinue medications for blood pressure control, cardiac or circulatory problems, diabetes or other medications for similar medical disorders. If you have any concerns about medications, please call our office at (502) 584-3573.

Also DO NOT:

- Do not eat or drink anything for a period of three (3) hours before the time of the test.
- Do not drink any caffeinated beverages on the day of the test.
- Do not use any tobacco products on the day of the test.
- Do not wear make-up or face cream the day of the test.

***** *If you wear contacts, you will need to remove them for this test.* *****

Again, thank you for choosing Heuser Hearing Institute. If you have any further questions or need additional instructions, please call our clinic at (502) 584-3573.

Heuser Hearing Institute
Heuser Hearing & Language Academy

Name _____ Date _____

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

1.	Does looking up increase your problem? P	☐ Yes ☐ Sometimes ☐ No
2.	Because of your problem, do you feel frustrated? E	☐ Yes ☐ Sometimes ☐ No
3.	Because of your problem, do you restrict your travel for business or recreation? F	☐ Yes ☐ Sometimes ☐ No
4.	Does walking down the aisle of a supermarket worsen your problem? P	☐ Yes ☐ Sometimes ☐ No
5.	Because of your problem, do you have difficulty getting into or out of bed? F	☐ Yes ☐ Sometimes ☐ No
6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing or to parties? F	☐ Yes ☐ Sometimes ☐ No
7.	Because of your problem, do you have difficulty reading? F	☐ Yes ☐ Sometimes ☐ No
8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? P	☐ Yes ☐ Sometimes ☐ No
9.	Because of your problem, are you afraid to leave home without having someone with you? E	☐ Yes ☐ Sometimes ☐ No
10.	Because of your problem, have you been embarrassed in front of others? E	☐ Yes ☐ Sometimes ☐ No
11.	Do quick movements of your head increase your problem? P	☐ Yes ☐ Sometimes ☐ No
12.	Because of your problem, do you avoid heights? P	☐ Yes ☐ Sometimes ☐ No
13.	Does turning over in bed worsen your problem? P	☐ Yes ☐ Sometimes ☐ No
14.	Because of your problem, is it difficult for you to do strenuous housework or yard work? F	☐ Yes ☐ Sometimes ☐ No
15.	Because of your problem, are you afraid people may think you are intoxicated? E	☐ Yes ☐ Sometimes ☐ No
16.	Because of your problem, is it difficult for you to go for a walk by yourself? F	☐ Yes ☐ Sometimes ☐ No
17.	Does walking down a sidewalk worsen your problem? P	☐ Yes ☐ Sometimes ☐ No
18.	Because of your problem, is it difficult for you to concentrate?	☐ Yes ☐ Sometimes ☐ No
19.	Because of your problem, is it difficult for you to go for a walk around your house in the dark? F	☐ Yes ☐ Sometimes ☐ No
20.	Because of your problem, are you afraid to stay home alone? F	☐ Yes ☐ Sometimes ☐ No
21.	Because of your problem, do you feel handicapped? E	☐ Yes ☐ Sometimes ☐ No
22.	Has your problem placed stress on your relationship with members of your family or friends? E	☐ Yes ☐ Sometimes ☐ No
23.	Because of your problem, are you depressed? E	☐ Yes ☐ Sometimes ☐ No
24.	Does your problem interfere with your job or household responsibilities? F	☐ Yes ☐ Sometimes ☐ No
25.	Does bending over worsen your problem? P	☐ Yes ☐ Sometimes ☐ No

F _____ (36) E _____ (36) P _____ (28) Total _____ (100)

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