EARS IN BALANCE, INC.

EARS IN BALANCE, INC
31313 Northwestern Hwy, Suite 216
Farmington Hills, MI 48334

Dear Patient,

You are scheduled for a series of hearing and balance tests which require us to block time for the Audiologist. Please call us 24 hours prior to testing if you are unable to make the appointment, so we may offer that slot to another patient.

In the event you fail to show up for the appointment, there will be a charge of $50.00 for a no show.

Please make every attempt to keep the appointment as it is for your wellbeing, and it will help us take further better care of you. Should you have any questions, please call 248. 900.EARS (3277)

Thank you,

Ears in Balance Team

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Videonystagmography (VNG) Test

Videonystagmography (VNG) is a test that measures a type of involuntary eye movement callednystagmus. These movements can be slow or fast, steady, or jerky.

Your Physician may require a VNG test if you have symptoms of a vestibular disorder. The main symptom is dizziness, a general term for different symptoms of imbalance. These include vertigo, a feeling that you or your surroundings are spinning, staggering while walking, and lightheadedness, a feeling like you are going to faint.

Other symptoms of a vestibular disorder include:

Nystagmus (involuntary eye movements that go side to side or up and down)
Ringing in the ears (tinnitus)
Feeling of fullness or pressure in the ear
Confusion

An extensive evaluation is required at times to determine the cause of the above symptoms. The tests necessary to diagnose your problem have been determined by your doctor at the time of examination and may include detailed hearing and balance tests. The object of this evaluation is to be certain that you have a disorder of the inner ear. An abnormal result may also mean you have a condition that affects the parts of the brain that helps control your balance. This lays the groundwork for effective medical or surgical treatment by your doctor.

The **Videonystagmography (VNG)** test is the electronic recording of Nystagmus (eye jerks). During a VNGtest, you will sit in a semi dark room and wear special goggles. The goggles have a camera that records eye movements. There are three main parts to a VNG:

- **Ocular testing.** During this part of the VNG, you will watch and follow moving and nonmovingdots on a light bar.
- **Positional testing.** During this part, your provider will move your head and body in differentpositions. Your provider will check if this movement causes nystagmus.
- **Caloric testing.** During this part, warm and cool water or air will be put in each ear. When coldwater or air enters the inner ear, it should cause nystagmus. The eyes should then move away from the cold water in that ear and slowly back. When warm water or air is put in the ear, the eyes should move slowly toward that ear and slowly back. If the eyes don't respond in these ways, it may mean there is damage to the nerves of the inner ear. Your provider will also check to see if one ear responds differently from the other. If one ear is damaged, the response will beweaker than the other, or there may be no response at all.

Welcome to EARS IN BALANCE

Ears In Balance is a multi-specialty center which provides Audiology Services, high quality Hearing Aids customized to patient hearing loss and provide evaluation and treatment of dizziness and balance disorders. We are affiliated to the American Institute of Balance whose therapy programs are used by physicians, audiologists, and therapists worldwide. We strive to provide consistent, high-quality, evidence-based care in balance health to all our patient

What to Expect at your Appointment?

Your visit will include a variety of simple but technically advanced tests using computers and highly specialized equipment not available in most medical centers. There will be no pins or needle sticks. Your appointment will last 60 – 90 minutes.

Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

We will be sure to discuss the results whenever possible and send all results to your referring physician.

DOs and DON'Ts

In order to obtain accurate results, we ask that you please review the following instructions carefully:

1. Do bring your Photo ID, Insurance Card and List of Medications.
2. Do not wear any makeup, including mascara, eye liner, or face lotions. These products might interfere with the recordings. Please dress comfortably.
3. Do not drink alcoholic beverages for 48 hours before the test.
4. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment. Anti-vertigo medicines: Anti-vert, Ru-vert, or Meclizine; Anti-nausea medicine: Atarax, Dramamine, Compazine, Antiver, Bucladin Phenergan,Thorazine, Scopalomine, Transdermal.
5. Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.
6. Eat lightly the day of your appointment. If your appointment is in the morning, you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat alight breakfast and have a light snack for lunch.
7. Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. However, if this is not possible, try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office

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Please follow instructions carefully before coming for you Balance tests. Failure to do so will result in wrong diagnosis. Ensure that you have an accompanying driver to take you back home after the tests.

Patient Name: _____DOB: _____

BALANCE QUESTIONNAIRE

Patients: In order to fully evaluate your complaints, please complete all questions and bring this survey with you when you return for you balance function testing.

1. Describe symptoms / complaints in detail:

2. When did symptoms begin:

3. How long do symptoms last (circle answers):

   Seconds Minutes Hours Days

4. How often do symptoms occur:

   Constant Daily Weekly Monthly Yearly

5. Symptoms occur when:

   Walking Standing Sitting Laying Anytime

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	NO	YES	Comments
Imbalance / Unsteadiness			
History of falling			
Spinning / Tumbling			
Rocking / Swaying			
Lightheadedness			
Fainting / Black Out			
Nausea / Vomiting			
Double Vision			
Jumping Vision (while walking / Riding)			

Are symptoms worsened by:

	NO	YES	Comments
Lying down or rolling over			
Sitting or standing up			
Walking in darkness			
Rocking / Swaying			
Walking on uneven surfaces			
Hot baths / showers			
Menstrual Cycle			
Exercise			
Reading / Computer work			
Loud Noises			
Coughing, Sneezing, Straining			

Ears / Eyes:

	NO	RIGHT	LEFT	Comments
Fluctuating Hearing				
Tinnitus (ringing, buzzing, etc.)				
Frequent Ear Infections				
Perforated / Torn Eardrum				
Ear Surgery				
Ear Injuries				
Eye Injury				
Eye Surgery				
Use of Eye Patch				

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Patient Name: _____DOB: _____

Headache History

Headaches : No Yes

How often do they occur : Daily Weekly Monthly

How long do they last? : Minutes Hours Days

Headache medications List : _____

Migraine : No Yes

Since how long? : _____

With nausea / vomiting : No Yes

Caused by certain food / drink: No Yes

Family history of migraine : No Yes

Related to Menstrual cycle : No Yes

Habits: _____
Alcohol: _____
Caffeine: _____
Tobacco: _____
Recreation Drug: _____

Past Medical History: Please Describe and list dates.

_____

_____

Motor Vehicle Accident:
Head Injury:
Chronic Illness (e.g., diabetes, hypertension) requiring medication:
Intravenous antibiotics, chemotherapy, radiation therapy:
Medications: Please List

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Patient Name: _____DOB: _____

Tinnitus Handicap Inventory

The purpose of the scale is to identify the problems your tinnitus may be causing you.

Circle "YES," "Sometimes," or "NO" for each question. Do not skip a question.

1. Because of your tinnitus is it difficult to concentrate?	Yes / Sometimes / No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes / Sometimes / No
3. Does you tinnitus make you angry?	Yes / Sometimes / No
4. Does your tinnitus make you feel confused?	Yes / Sometimes / No
5. Because of your tinnitus do you feel desperate?	Yes / Sometimes / No
6. Do you complain a great deal about your tinnitus?	Yes / Sometimes / No
7. Because of your tinnitus do you have trouble falling to sleep at night?	Yes / Sometimes / No
8. Do you feel that you cannot escape your tinnitus?	Yes / Sometimes / No
9. Does your tinnitus interfere with your ability to enjoy social activities (such as going out to dinner, to the movies)?	Yes / Sometimes / No
10. Because of your tinnitus do you feel frustrated?	Yes / Sometimes / No
11. Because of your tinnitus do you feel that you have a terrible disease?	Yes / Sometimes / No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes / Sometimes / No
13.Does your tinnitus with your interfere with your job or household duties?	Yes / Sometimes / No
14. Because of your tinnitus do you find that you are often irritable?	Yes / Sometimes / No
15. Because of your tinnitus is it difficult for you to read?	Yes / Sometimes / No
15. Does your tinnitus make you upset?	Yes / Sometimes / No
17. Do you feel that your tinnitus problem has place stress on your relationship with members of your family and friends?	Yes / Sometimes / No

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Tinnitus Handicap Inventory

18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes / Sometimes / No
19. Do you feel that you have no control over your tinnitus?	Yes / Sometimes / No
20. Because of your tinnitus do you often feel tired?	Yes / Sometimes / No
21. Because your tinnitus do you feel depressed?	Yes / Sometimes / No
22. Does your tinnitus make you feel anxious?	Yes / Sometimes / No
23. Do you feel that you can no longer cope with your tinnitus?	Yes / Sometimes / No
24. Does your tinnitus get worse when you are under stress?	Yes / Sometimes / No
25. Does your tinnitus make you feel insecure?	Yes / Sometimes / No