



## Dizziness/Balance Evaluation Patient Instructions

You are scheduled for a test of your balance system. There are a few things you should know prior to your appointment.

### Medications:

Certain medications affect the test results. Below is a partial list of medications that **should not be taken for 48 hours prior to the test**. Ask your doctor if you have concerns about discontinuing your medications.

- **Alcohol** – beer, wine, liquor, cough medicine
- **Analgesics/Narcotics** – Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet
- **Anti-histamines** – Chlor-trimeton, Disophrol, Benadryl, Teldrin, Hismanol, Claritin, Allegra, Zyrtec, nearly all over-the-counter allergy or cold medicines
- **Anti-vertigo** – Antivert, Meclizine, Ru-vert
- **Anti-nausea** – Atarax, Dramamine, Compazine, Amtivert, Bucladin, Phenergan, Thorazine, Scopalamine, nearly all motion sickness patches or medications
- **Sedatives** – Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pills
- **Tranquilizers** – Librium, Atarax, Vistaril, Serax, Ativa, Librax, Tranxene, Xanax

**You may take blood pressure medications, heart medications, thyroid medications, Tylenol, insulin and estrogen.**

**Always consult with your doctor before discontinuing any prescribed medications.**

### Other limitations:

- NO caffeine (coffee, soda, tea, etc.) for 4 HOURS before the test
- NO smoking for 4 HOURS before the test
- NO eating for 2 HOURS before the test

### For your comfort and convenience:

- Dress comfortably. Women should avoid wearing skirts or dresses as part of the test requires lying down. You may want to wear or bring a sweater as it generally stays cool in our office.
- **Do not wear any makeup** – some tests will require placing small adhesive electrodes on the face and neck.
- Do not wear contact lenses that day. Wear your glasses instead.

### About the testing:

A comprehensive battery of testing will be performed during the approximately **4-hour** appointment allocated for you. Prior to each test, an explanation will be given so that you will better understand what is being tested and why. The tests are simple and painless. One or two of the tests may cause a sensation of motion that may linger. If possible, **we encourage you to have someone with you for driving purposes**. If this is not possible, plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

Once your testing is completed, each part is carefully analyzed and reviewed. This process is as important as your testing, so please understand that **your test results will not be discussed in detail with you until several days after your visit**. Following the interpretation of the testing, you will return for a visit to review your results with your audiologist. A detailed report will also be sent to your referring physician regarding our conclusions and recommendations. Please contact our office if you have any further questions or concerns. We are looking forward to your visit.



**Patient Information (Please complete all entries.)**

Patient Name (Last/First/Middle) Mr./Ms./Mrs.		Sex M F	Date of Birth	Age	Social Security Number
Address (Street/City/State/Zip)		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
		Driver's License Number			
		Home Phone No. ( )			
Name of Employer		Work Phone No. ( )			
Employer's Address (Street/City/State/Zip)	Occupation	Email Address			
Name of Spouse (Last/First/Middle)		Date of Birth	Age	Social Security Number	
Spouse's Employer		Spouse's Work Phone No. ( )			
Nearest Relative Not Living With You		Relative's Phone No. ( )			
In Case of Emergency, Notify		Emergency Contact's Phone No. ( )			
Primary Care Physician		Phone No. ( )			
Whom May We Thank for Referring You to Us?		Phone No. ( )			
Who is Financially Responsible for Payment?		I Will Be Paying Today By <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Insurance			

**Insurance Information**

Primary Insurance Name	Address (City/State/Zip)		Phone No. ( )
Name of Insured	Relationship	I.D. No.	Group No.
Secondary Insurance Name	Address (City/State/Zip)		Phone No. ( )
Name of Insured	Relationship	I.D. No.	Group No.

I understand and agree that I am ultimately responsible and liable for amount not paid by my insurance company.

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

I authorize payment of medical benefits to:  
Newport-Mesa Audiology Balance & Ear Institute, Howard T. Mango, Au.D., Ph.D., 500 Newport Blvd., Suite 101, Newport Beach, CA 92663

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

I authorize release of any medical information necessary to process this claim.

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

I understand that under the Medicare and/or Medicare supplemental insurance payment plan, I am liable for Medicare deductible for the year. I am also liable for supplemental insurance amount only if the supplemental insurance company sends the check to insured.

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

<b>Health Questionnaire (Please complete all entries.)</b>	<b>Date</b>
Patient Name (Last/First/Middle)	Social Security Number

**A. Reason for Visit:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**B. Medication:** List all medications that you are taking. Include over-the-counter drugs.

Name	Strength	Frequency

Have you had any of the above medications in the past 48 hours?  Yes  No  
 Do you have any allergies to medications?  Yes  No  I don't know. If known, please list below:  
 \_\_\_\_\_

**C. Medical History:** List all surgeries and medical conditions. If applicable, list the year and the reason for any hospital admissions. Do not include normal pregnancies.

Year	Condition/Illness/Surgery	Length

**D. Miscellaneous Information:** Please check appropriate box and give amount.

- Do you smoke?  No  Yes \_\_\_\_\_ packs per day
- Do you drink alcohol?  No  Yes \_\_\_\_\_ glasses per day, week, month
- Do you drink caffeine products (tea, coffee, soda)?  No  Yes \_\_\_\_\_ cups per day, week, month

**E. Family History:**

1. List all family members with a history of hearing loss or ear problems.

Relationship	Age	Type of Hearing Loss/ Ear Problem

2. Please circle any of the following diseases which are common in your family, or have occurred in any family member. Do not include family members by marriage or adoption.

- |                     |               |                     |                        |
|---------------------|---------------|---------------------|------------------------|
| asthma              | diabetes      | high blood pressure | surgical complications |
| auto immune disease | hay fever     | kidney disease      | stroke                 |
| bleeding disorder   | heart disease | migraine            | tuberculosis           |
| cancer              |               |                     |                        |

**F. Symptom Review:** Please circle to indicate if you had have any of the following symptoms or diseases.

**Neurological**

stroke  
migraine  
blackout spells  
weakness or paralysis  
terror/hand shaking  
head injury  
numbness/tingling  
sensations  
muscle pains  
significant arthritis  
muscle irritation/tenderness

**Respiratory**

pneumonia  
tuberculosis  
asthma  
chronic cough  
shortness of breath

**Blood/Lymphatic**

bleeding disorder  
anemia  
previous transfusions  
easy bruising

**Head and Neck**

meningitis  
dry mouth  
headaches  
glaucoma  
sneezing or runny nose  
sinus trouble  
dry eyes  
eye disease or poor vision

**Urinary**

kidney disease  
prostate problems  
kidney stones  
blood in urine

**Gynecological**

pregnancy  
currently breast feeding  
vaginitis

**Infectious**

AIDS  
HIV positive  
venereal disease  
syphilis  
gonorrhea  
tuberculosis  
chicken pox  
German measles  
mumps  
scarlet fever

**Emotional**

nervous breakdown  
depression  
chronic fatigue  
suicidal tendencies  
anxiety

**Dermatologic**

rashes  
boils  
eczema  
psoriasis  
sun sensitivity

**Endocrine**

hormone therapy  
thyroid  
diabetes

**Gastrointestinal**

constipation  
diarrhea  
ulcer  
heart burn  
liver disease  
pancreatitis

**Cardiovascular**

heart attack  
angina/chest pain  
any heart trouble  
heart murmur  
arrhythmia  
high blood pressure  
rheumatic fever

**General**

cancer

**G. Ear Disease:** Please circle Yes or No.

- Yes No 1. Have you had your hearing tested?  
 Yes No 2. Have you ever been to a doctor for ear trouble?  
 Yes No 3. Have you ever had ear surgery?  
 Yes No 4. Have you ever worn hearing aids?  
 Yes No 5. Do you wear hearing aids now?  
 Yes No 6. Have any blood relatives with a hearing loss?  
 Yes No 7. Today, do you have any of the following?  
     Please circle.  
     Allergies           Ear Pressure  
     Cold                Ear Drainage  
     Dizziness          Ear Infection  
                             Ear Pain
- Yes No 8. Are you bothered by ringing noises?  
 Yes No 9. Are you now taking more than a few aspirins a day?  
 Yes No 10. Have you ever taken large doses of aspirin? Anacin, Bufferin, Emperin, or Quinine? How many? \_\_\_\_\_ /day  
 Yes No 11. Have you ever taken medications known to be damaging to your ears?  
 Yes No 12. Have you ever received injections of any antibiotics of the mycin family? (gentamycin, kanamycin, vancomycin)  
 Yes No 13. Do you have ear drainage or pain?  
 Yes No 14. Have you ever suffered a severe head injury?  
 Yes No 15. Do you have more difficulty understanding speech today than you did five years ago?  
 Yes No 16. Do you have difficulty listening to music?  
 17. How is your hearing? Please circle.  
     Good      Fair      Poor

- Did you ever or do you now participate in (or use) any of the following? (answer each)
- Yes No 18. Motorcycling  
 Yes No 19. Target shooting  
 Yes No 20. Hunting  
 Yes No 21. Snowmobiling  
 Yes No 22. Auto racing  
 Yes No 23. Power tools  
 Yes No 24. Musical instruments  
 Yes No 25. Private airplanes  
 Yes No 26. Any job that is noisy  
 Yes No 27. Farm equipment  
 Yes No 28. Chainsaws  
 Yes No 29. Were you in the military service or National Guard? What was your job? \_\_\_\_\_  
 Yes No 30. Have you in your job or hobbies, been exposed to loud noise levels? (machinery, gunfire, rock music, etc.)  
 Yes No 31. Do you wear hearing protection away from work? When started? \_\_\_\_\_  
 Yes No 32. Were you working around loud noise during the last 14 hours?  
 Yes No 33. Were you wearing hearing protection prior to this test today?  
 Yes No 34. Do you have trouble understanding in crowds, in church or at meetings?  
 Yes No 35. Do you have trouble understanding speech on the telephone?



## Notice of Privacy Practices

### To Our Patients

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### Our Commitment to Your Privacy

- Our practice is dedicated to maintaining the privacy of your health information.
- We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

### Use and Disclosure of Your Health Information in Certain Special Circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or another individual or the public.  
We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

### Your Right Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact your home, rather than work. This may include contacting you by way of non-secured devices, such as answering machines, cellular phones, pagers, etc. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information only to certain individuals in our care, such as family members and friends. If we do agree to your request, we are bound by agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Newport-Mesa Audiology Balance & Ear Institute, 500 Old Newport Blvd., Suite 101, Newport Beach, CA 92663, (949) 642.7935. You must provide us with a reason that supports your request for amendment.
4. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
5. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Newport-Mesa Audiology Balance & Ear Institute, 500 Old Newport Blvd., Suite 101, Newport Beach, CA 92663, (949) 642.7935.
6. Right to provide authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Newport-Mesa Audiology Balance & Ear Institute, 500 Old Newport Blvd., Suite 101, Newport Beach, CA 92663  
Phone: (949) 642.7935 • Fax: (949) 642-2950 • [www.dizziland.com](http://www.dizziland.com)



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[dizziland.com](http://dizziland.com)

I hereby sign this in acknowledgement that I have been presented with a copy of Dr. Howard T. Mango's Notice of Privacy Practices.

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Name of Patient

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Signature

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Date



<b>Dizziness Questionnaire (Please complete all entries.)</b>	<b>Date</b>	
Patient Name (Last/First/Middle)	Age	Sex

1. Please describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. When did these symptoms begin? \_\_\_\_\_

3. Did your symptoms come on gradually or suddenly? \_\_\_\_\_

4. Have symptoms become worse (More frequent? More severe?) or have they improved? \_\_\_\_\_

**5. Check all that apply to your dizzy spells:**

- |  |   |
|--|---|
| <input type="checkbox"/> Preceded by flu/ cold                                     | <input type="checkbox"/> Better if sit or lie still   |
| <input type="checkbox"/> Spinning sensation  | <input type="checkbox"/> Fullness/ pressure/ ringing in the ears  |
| <input type="checkbox"/> Falling on one side:<br>Which side? _____                 | <input type="checkbox"/> Imbalance when walking.<br>Veering to which side? _____  |
| <input type="checkbox"/> Trouble walking in the dark                               | <input type="checkbox"/> Comes in attacks:<br>How often? _____  |
| <input type="checkbox"/> No symptoms between attacks                               | How long do they last? <input type="checkbox"/> Seconds <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days |
| <input type="checkbox"/> Nausea  | When was the last? _____  |
| <input type="checkbox"/> Vomiting  | <input type="checkbox"/> More dizzy in certain positions:<br>Which positions? _____   |
| <input type="checkbox"/> Perspiration, shortness of breath,<br>or feeling of panic |   |
| <input type="checkbox"/> Lightheadedness or swimming sensation                     |   |

**6. Check all that apply to other sensations you may have:**

- |  |   |
|--|---|
| <input type="checkbox"/> Blacking out or fainting when dizzy | <input type="checkbox"/> Tingling around mouth            |
| <input type="checkbox"/> Dizzy or unsteady constantly        | <input type="checkbox"/> Spots before eyes                |
| <input type="checkbox"/> Severe or recurrent headaches       | <input type="checkbox"/> Jerking of arms or legs          |
| <input type="checkbox"/> Double or blurry vision             | <input type="checkbox"/> Dizzy when stand up quickly      |
| <input type="checkbox"/> Numbness in the face or extremities | <input type="checkbox"/> Weakness/ faintness after eating |
| <input type="checkbox"/> Weakness/ clumsiness in arms, legs  | <input type="checkbox"/> Difficulty swallowing            |
| <input type="checkbox"/> Slurred or difficult speech         |   |

## Dizziness Questionnaire (continued)

### 7. Check all that apply to your hearing:

- |   |            |   |            |
|---|------------|---|------------|
| <input type="checkbox"/> Difficulty hearing | Right/Left | <input type="checkbox"/> Exposure to loud noise       | Right/Left |
| <input type="checkbox"/> Ringing            | Right/Left | <input type="checkbox"/> History of ear infection     | Right/Left |
| <input type="checkbox"/> Fullness           | Right/Left | <input type="checkbox"/> Change in hearing when dizzy | How? _____ |
| <input type="checkbox"/> Pain               | Right/Left | <input type="checkbox"/> Previous ear surgery         | Right/Left |
| <input type="checkbox"/> Discharge          | Right/Left | When/what: _____                                      |            |
| <input type="checkbox"/> Hearing changing   | Right/Left |   |            |

### 8. Check all that apply to your medical history:

- |  |  |
|--|--|
| <input type="checkbox"/> Head injury           | <input type="checkbox"/> Arthritis                         |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Diabetes                          |
| <input type="checkbox"/> Allergies: _____      | <input type="checkbox"/> Thyroid disease                   |
| _____  | <input type="checkbox"/> Heart disease                     |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Asthma                            |
| <input type="checkbox"/> Low blood pressure    | <input type="checkbox"/> Migraine headaches                |
| <input type="checkbox"/> Mental illness        | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Seasickness or car sickness       |
| <input type="checkbox"/> Back or neck injury   | <input type="checkbox"/> Motion intolerance                |
| <input type="checkbox"/> Back or neck pain     | <input type="checkbox"/> Sensitivity to light and/or sound |

### 9. Check those that may be linked to your dizziness:

- |   |  |
|---|--|
| <input type="checkbox"/> Stress               | <input type="checkbox"/> Recent change in eyeglasses |
| <input type="checkbox"/> Menstrual period     | <input type="checkbox"/> Headaches                   |
| <input type="checkbox"/> Hormonal changes     | <input type="checkbox"/> Loud noises                 |
| <input type="checkbox"/> Overwork or exertion | <input type="checkbox"/> Diet                        |

10. What tests have been done previously for your dizziness? (hearing test, MRI, CT, bloodwork, etc.)? \_\_\_\_\_

11. Do you have anything else to tell us about this problem that we haven't asked on this form? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## Dizziness Handicap Inventory

Name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

1.	Does looking up increase your problem? (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
2.	Because of your problem, do you feel frustrated? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
3.	Because of your problem, do you restrict your travel for business or recreation? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
4.	Does walking down the aisle of a supermarket increase your problem? (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
5.	Because of your problem, do you have difficulty getting into or out of bed? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
7.	Because of your problem, do you have difficulty reading? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
9.	Because of your problem, are you afraid to leave your home without having someone accompany you? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
10.	Because of your problem, have you been embarrassed in front of others? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
11.	Do quick movements of your head increase your problem? (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
12.	Because of your problem, do you avoid heights? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
13.	Does turning over in bed increase your problem? (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
14.	Because of your problem, is it difficult for you to do strenuous housework or yard work? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
15.	Because of your problem, are you afraid people may think you are intoxicated? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
16.	Because of your problem, is it difficult for you to walk by yourself? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
17.	Does walking down a sidewalk increase your problem? (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
18.	Because of your problem, is it difficult for you to concentrate? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No

19.	Because of your problem, is it difficult for you to walk around your house in the dark? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
20.	Because of your problem, are you afraid to stay home alone? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
21.	Because of your problem, do you feel handicapped? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
22.	Has your problem placed stress on your relationships with members of your family or friends? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
23.	Because of your problem, are you depressed? (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
24.	Does your problem interfere with your job or household responsibilities? (F)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No
25.	Does bending over increase your problem? (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> No

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**This section will be completed by your clinician.**

**Scoring:** Yes = 4 points; Sometimes = 2 points; No = 0 points

Functional Subscale = F

**Functional Subscale:** \_\_\_\_\_ /36

Emotional Subscale = E

**Emotional Subscale:** \_\_\_\_\_ /28

Physical Subscale = P

**Physical Subscale:** \_\_\_\_\_ /30

**Total Score:** \_\_\_\_\_ /100