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.

Revised 03/2019
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.

Revised 11/18
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
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:__________________

Revised 3/15
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: Eyes:
Recent weight change loss of vision
Fever Pain
Fatigue 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

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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Provider Signature ___________________ Date ___________________

Revised 11/2018