Computerized Dynamic Posturography (CDP) & Videonystagmography (VNG) Packet

Name:
DOB:
DOS:

Audiologist: ☐Nicole Smith, Au.D ☐Trista Williams, Au.D
Location:

Balance Clinic Information

At the DeFatta ENT & Facial Plastic Surgery clinic, we understand that experiencing dizziness (vertigo) can greatly impact quality of life. Dizziness can lead to falls or injuries, loss of time at work, and even limit your independence. Our team at DeFatta ENT & Facial Plastic Surgery clinic is dedicated to providing a comprehensive approach to managing and treating dizziness and imbalance. You will notice compassionate, patient-centered care whether presenting to one of our Ear, Nose, and Throat (ENT) Physicians for medical management or to our audiologists for diagnostic testing. If physical therapy is recommended, we are willing to work closely with your physical therapy team to explain results of our testing or to monitor progress.

Testing Information

Below is a brief outline of the testing you can expect at our center. Your ENT physician has ordered one or both of these tests to further assess your dizziness and imbalance.

- Computerized Dynamic Posturography (CDP) testing:
  - Our bodies have three systems that are important for maintaining balance:
    - Visual system (eyes)
    - Vestibular system (the inner ear)
    - Somatosensory system (sense of touch)
  - Problems with any of the three systems can affect your sense of balance.
    - This is what may lead to falls or injuries.
  - CDP testing allows the audiologist to independently evaluate each system to help determine the source of your dizziness or imbalance.
- Videonystagmography (VNG) testing:
  - Sometimes, the inner ear can be a contributing factor to dizziness; VNG testing is performed to help rule this out.
    - VNG testing can help determine if one ear or both ears are affected.
  - VNG testing requires the use of special goggles to record your eye movements as you track a visual object, and as your vestibular, or balance, system responds to different test conditions.
  - VNG testing also requires the use of warm or cold air presented to the ear canal.
    - This test is designed to make you feel dizzy in order to determine whether the vestibular system (inner ear) is contributing to your dizzy symptoms.

Test Preparation Information

- **Before the Test:**
  - Avoid a heavy meal before the test
  - Avoid alcohol and cigarettes for 48-72 hours before the test
  - Avoid caffeine use for 24 hours before the test
- **Day of the Test:**
  - Wear comfortable clothing
  - Remove contacts – bring glasses if necessary
  - Avoid wearing any makeup especially **eye liner/mascara** – be sure to have a face clean of make-up or lotion
- **After the Test:**
  - **<u>*Do not drive, PLEASE BRING A DRIVER– dizziness may persist*</u>**

Medications that Interfere with Balance Testing

Certain medications and substances can interfere with the test results that determine what is causing your dizziness or balance problem. Talk to your physician to see if you can be off of the follow medications 24 hours before your appointment.

<u>DO NOT</u> USE OR TAKE ANY OF THE FOLLOWING TYPES OF SUBSTANCES OR MEDICATIONS
FOR 24 HOURS BEFORE YOUR APPOINTMENT:

- Alcoholic beverages (*beer, wine, liquor*)
- Nicotine (*cigarettes, chewing tobacco, snuff, cigars, pipes*)
- Caffeine (*soft drinks, coffee, tea, diet pills containing caffeine*)
- Anti-dizziness pills (*Antivert, Dramamine, Meclizine, Transderm Scopolamine, Valium*)
- Sleeping pills
- Pain medications or muscle relaxers (*Darvocet, Demerol, Duragesic, Flexeril, Hydrocodone, Hydromorphone, Hydroxyzine, Lorcet, Morphine, MS Contin, Norflex, Norgesic, Norgesic Forte, Oxycodone, Oxycontin, Percocet, Percodan, Propoxyphene, Robaxin, Salsalate, Skelaxin, Soma, Stadol, Ultram, Ultracet, Zanaflex, etc.*)
- Antihistamines or cold and sinus medicines (*Actifed, Alavert, Allegra, Benadryl, Chlor-Trimeton, Clarinex, Claritin, Dimetapp, Diphenhydramine, Tavist, Zyrtec, etc.*)
- Diuretics or fluid pills (*HCTZ, Furosemide, Lasix, etc.*)
- Any medicines that have a sedating or stimulating effect

Patient History

Instructions: If you have dizziness, please complete the following history form.

*******If you have hearing loss, please ask for the Hearing Loss History Form.***

*******If you are troubled by ear noises, such as buzzing or ringing, please ask for the Tinnitus History Form.***

Current Symptoms: ☐ None ☐ Currently experiencing

(Fill out form even if you are currently not experiencing symptoms)

1. Describe your dizziness: Check all that apply

☐ Dizziness ☐ Spinning sensation

☐ Sensation of movement ☐ Loss of balance

☐ Difficulty moving around

2. Associated Symptoms:

a. Hearing loss	☐ Yes (*if yes answer questions below*)	☐ No (Skip to b.)
Onset:	☐ Gradual ☐ Sudden	
Location:	☐ Both ears ☐ Right ear ☐ Left ear	
Does your hearing ability change/fluctuate? If Yes please describe:		
Trigger/Cause:		
b. Nausea	☐ Yes (*If yes answer questions below*)	☐ No (Skip to c.)
When does this occur?		
Does anything make your nausea better? Worse? If Yes please describe:		
c. Vomiting	☐ Yes (*If yes answer questions below*)	☐ No (Skip to 3)
If Yes please describe:		
Does anything make your vomiting better? Worse? If Yes please describe:		

3. When did your first episode of dizziness occur?

_____ Days ago _____ Months ago _____ Years ago

4.Occurred with the onset of your dizziness: Check all that apply

☐ Viral illness
☐ Upper respiratory infection
☐ Ear infection
☐Head trauma
☐ Ear trauma
☐ Other: _____

5. How often do your symptoms occur?

☐Hourly _____ Per hour
☐Daily _____ Per day
☐Weekly _____ Per week
☐Monthly _____ Per month

6. How long do your Symptoms last?

☐ _____ Minutes
☐ _____ Hours
☐ Constant
☐ _____ Days
☐ _____ Months
☐ Other: _____

7. Severity Level

☐Mild ☐Moderate ☐Severe

8. Progression Level

☐ Worsening
☐ Resolved
☐ Improving
☐ Unchanged
☐ Other: _____

9. What makes your dizziness worse? Check all that apply

☐ Nothing
☐ Head movement
☐ Turning head direction: _____
☐ Flexing neck
☐ Looking up
☐ Bending over
☐ Lying down
☐ Other:
☐ Rolling over
☐ Straining
☐ Standing

10. What makes your dizziness better? Check all that apply

☐ Nothing
☐ Rest
☐ Medicine: _____
☐ Lying still
☐ Avoiding head movement
☐ Other: _____

11. Other Symptoms not listed:

12. Current treatment:

☐ None
☐ Medicine: _____
_____

☐ Salt restriction
☐ Vestibular exercise
☐ Other: _____

13. Medical History: Check all that apply

☐ Meniere's Disease
☐ Migraine
☐ Cerebrovascular disease

Have you been exposed to any of the following: Check all that apply

☐ Aminoglycosides (antibiotics)
☐ Chemotherapeutic agents
☐ Ototoxic drugs
☐ Carbon monoxide

Family History: Check all that apply

☐ Migraine
☐ Vertigo
☐ Other: _____

DeFatta ENT
FACIAL PLASTIC SURGERY

Activities Balance Confidence Scale

Name:
DOB:
DOS:

Audiologist: ☐Nicole Smith, Au.D ☐Trista Williams, Au.D
Location:

Instructions: Indicate your level of confidence while performing the activities below without losing balance or becoming unsteady. If you normally use a walking aid to do the activity, or if you hold onto someone, rate your confidence as if you were using these supports. Use the percentage scale:

No Confidence 0% 20% 40% 60% 80% 100% Complete Confidence

How confident are you that you will not lose balance or become unsteady when you: *(check one)*

	0%	20%	40%	60%	80%	100%
Walk around the house?	☐	☐	☐	☐	☐	☐
Get into or out of a car?	☐	☐	☐	☐	☐	☐
Walk up or down stairs?	☐	☐	☐	☐	☐	☐
Walk across a parking lot?	☐	☐	☐	☐	☐	☐
Bend over to pick up something from the floor?	☐	☐	☐	☐	☐	☐
Walk up or down a ramp?	☐	☐	☐	☐	☐	☐
Reach for something off a shelf at eye level?	☐	☐	☐	☐	☐	☐
Walk in a crowded mall while others walk past you?	☐	☐	☐	☐	☐	☐
Stand on tiptoes to reach for something high?	☐	☐	☐	☐	☐	☐
Are bumped into by other people at the mall?	☐	☐	☐	☐	☐	☐
Stand on a chair and reach for something?	☐	☐	☐	☐	☐	☐
Step on or off an escalator while holding onto the railing?	☐	☐	☐	☐	☐	☐
Sweep the floor?	☐	☐	☐	☐	☐	☐
Step on or off an escalator while not holding on?	☐	☐	☐	☐	☐	☐
Walk outside the house to a car in the driveway?	☐	☐	☐	☐	☐	☐
Walk on snowy and icy surfaces?	☐	☐	☐	☐	☐	☐

DeFatta ENT
FACIAL PLASTIC SURGERY

Dizziness Handicap Inventory (DHI)

Name:
DOB:
DOS:

Audiologist: ☐Nicole Smith, Au.D ☐Trista Williams, Au.D
Location:

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes," "no," or "sometimes" to each question. ***Answer each question as it applies to your dizziness or unsteadiness only.***

	Question	Yes	No	Sometimes
1P	Does looking up increase your problem?	☐	☐	☐
2E	Because of your problem, do you feel frustrated?	☐	☐	☐
3F	Because of your problem, do you restrict your travel for business or recreation?	☐	☐	☐
4P	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
5F	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
6F	Does your problem significantly restrict your participation in social activities (e.g., going out to dinner, the movies, dancing, or parties)?	☐	☐	☐
7F	Because of your problem, do you have difficulty reading?	☐	☐	☐
8P	Does performing more ambitious activities increase your problem (e.g., sports, dancing, or household chores such as sweeping or putting away the dishes)?	☐	☐	☐
9E	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
10E	Because of your problem, are you embarrassed in front of others?	☐	☐	☐
11P	Do quick movements of your head increase your problem?	☐	☐	☐
12F	Because of your problem, do you avoid heights?	☐	☐	☐
13P	Does turning over in bed increase your problem?	☐	☐	☐
14F	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
15E	Because of your problem, are you afraid people may think you are intoxicated?	☐	☐	☐
16F	Because of your problem, is it difficult for you to walk by yourself?	☐	☐	☐
17P	Does walking down a sidewalk increase your problem?	☐	☐	☐
18E	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
19F	Because of your problem, is it difficult for you to walk around the house in the dark?	☐	☐	☐
20E	Because of your problem are you afraid to stay at home alone?	☐	☐	☐
21E	Because of your problem, do you feel handicapped?	☐	☐	☐
22E	Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
23E	Because of your problem, are you depressed?	☐	☐	☐
24F	Does it interfere with your job or household responsibilities?	☐	☐	☐
25P	Does bending over increase your problem?	☐	☐	☐
		X4	**X0**	**X2**
	Score:			
	Total:			

For Office Use Only: P=	E=	F=
☐100-70 = severe perception of having a handicap	☐ 69-40 = moderate perception of handicap	☐ 39-0 = low perception of handicap