THE AFA BALANCE & HEARING INSTITUTE
A.T. STILL UNIVERSITY OF HEALTH SCIENCES

4838 E. Baseline Road. Suite #126. Mesa, Arizona 85206
Phone: (480)265-8067 Fax: (480)656-6316
Web: www.TheAFAInstitute.com Email: AFAInstitute@atsu.edu

PATIENT APPOINTMENT INFORMATION

YOUR APPOINTMENT IS SCHEDULED ON THIS DATE: ……

AT THIS TIME: ……..

PRIOR TO YOUR APPOINTMENT, PLEASE MAKE CERTAIN TO:

1. Complete the enclosed forms.
2. Bring the completed forms with you to the appointment (alternatively you may also fax or email them ahead of time).
3. Bring your insurance card and a valid I.D. to the appointment.
4. Plan ahead and arrive ***at least*** 15 minutes early.
5. If you are scheduled for balance (dizziness) testing, please review the *pre-test instructions* at least 24 hours prior to your appointment.

Note: Testing procedures take time and we have appointments scheduled throughout the day. For this reason, if you arrive late, you may be forced to wait or we may have to reschedule your appointment at our discretion.

If you have any questions or require further directions, please contact us at (480)265-8067.

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PRE-APPOINTMENT INFORMATION & INSTRUCTIONS

MEDICATIONS

Medications can affect your balance/dizziness evaluation by influencing the body's natural responses and thus giving a false or misleading result. As such, you will be instructed to refrain from taking certain medications 24 hours prior to your test date. If you have any questions or concerns about discontinuing your medications, please consult with your doctor.

Please do not take any of the following 24 hours prior to your appointment.

1. **Analgesics-Narcotics:** Codeine, Demerol, Phenaphen, Percocet, Darvocet
2. **Anti-histamines:** Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin or any other over-the-counter cough or cold remedies.
3. **Anti-seizure medicine:** Dilantin, Tegretol, Phenobarbital
4. **Anti-vertigo medicine:** Antivert, Ru-vert, Bonine, Meclizine
5. **Anti-nausea medicine:** Atarax, Dramamine, Compazine, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal
6. **Sedatives:** Halcion, Terstoril, Nembutal, Seconal, Dalmane or any other sleeping pill
7. **Tranquilizers:** Valium (Diazepam), Librium, Atarax, Vistaril, Serax, Ativan (Lorazepam), Librax, Tranxene, Klonopin, Xanax (Alprazolam)

You ***may continue to take*** all blood pressure medications, diabetic medications, heart medications, thyroid medications, Tylenol, estrogen, etc. Please consult with your physician before discontinuing any prescribed medication.

FOOD AND DRINK

Please refrain from smoking, eating or drinking large amounts 4 hours prior to testing. You may drink a small amount of water or eat a light snack. **Please avoid caffeine in beverages such as coffee or soft drinks.**

Beer, wine and liquor will affect your test results. **Please do not consume any alcoholic beverages for 12 hours prior to your appointment.**

OTHER INFORMATION

Please do not wear any makeup (especially eye makeup) and remove contact lenses before your appointment.

Dress comfortably (slacks are preferred, as you may be required to lie on an exam table).

Balance testing, while typically well tolerated, can sometimes leave you with a temporary feeling of dizziness or unsteadiness. If you have concerns you may want to consider having someone accompany you to/from your appointment.

On the day of your appointment, a single test or battery of tests will be performed. Prior to each test, a brief explanation will be given so that you will have a better understanding of what is being evaluated and why. We make every attempt for your visit to be comfortable and educational. Once your evaluation is complete, each exam will be carefully reviewed. The interpretation process is just as important as your testing so please understand that results may not be discussed in full detail on that day. Once the interpretation has been made, you and/or your doctor will receive a detailed report of your evaluation within one week.

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PATIENT INFORMATION

DUE TO HIPAA REGULATIONS **ALL** INFORMATION MUST BE FILLED OUT, OTHERWISE WE WILL NOT BE ABLE TO PROCESS YOUR CLAIM AND YOU MAY BE BILLED FOR MEDICAL SERVICES

LAST NAME :	FIRST NAME:
ADDRESS:	
CITY:	STATE: ZIP CODE:
DATE OF BIRTH : / /	SOCIAL SECURITY NUMBER: – –
MARITAL STATUS: ❒ Single ❒ Married ❒ Widow/er ❒ Divorced ❒ Separated	GENDER ❒ M ❒ F
HOME PHONE:	CELL PHONE:
MAY WE LEAVE MESSAGES FOR YOU AT THESE NUMBERS? YES NO	

MISC CONTACT INFORMATION

EMERGENCY CONTACT NAME:	RELATIONSHIP:
HOME PHONE #:	CELL PHONE #:
DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CARE OR TREAMENT WITH ANY PARTY (INCLUDING FAMILY MEMBERS) BESIDE YOURSELF? **IF YES,** NAME/ PHONE NUMBER:	
REFERRING PHYSICIAN NAME:	PHONE NUMBER:

How did you hear about us? ❒ Yellow pages ❒ Friend ❒ Newspaper ❒ Doctor's Office ❒ Internet

EMPLOYMENT

EMPLOYMENT STATUS :	❒ FULL TIME	❒ PART TIME	❒ SELF EMPLOYED	❒ RETIRED	❒ STUDENT
OCCUPATION:			MAY WE CONTACT YOU AT WORK : ❒ Yes ❒ No		
EMPLOYER:			WORK PHONE # ( )		
WORK ADDRESS:	City		State	Zip Code	

INSURANCE INFORMATION

***PRIMARY INSURANCE** CARRIER:*		
POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT):		
INSURANCE THROUGH EMPLOYER? ❒ Yes ❒ No	IF YES, EMPLOYER NAME:	
INSURED ID #:	GROUP #:	RELATIONSHIP TO PATIENT:
***SECONDARY INSURANCE** CARRIER:*		
POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT):		DATE OF BIRTH: / /
INSURANCE THROUGH EMPLOYER? ❒ Yes ❒ No	IF YES, EMPLOYER NAME:	
INSURED ID #:	GROUP #:	RELATIONSHIP TO PATIENT:

Authorization to Release information and assignment of Benefits

I authorize payments of medical benefits to the provider for service rendered or to be rendered in the future without obtaining my signature on each claim submitted. I also authorize the release of any medical information necessary. I understand that I could be subject to a cancellation fee for each appointment missed where no notice is given or less than 24 hours of notice given. I am responsible for all charges regardless of insurance coverage. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand this office policy and procedure.

SIGNATURE:	**DATE :**

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A.T. STILL UNIVERSITY CENTER OF EXCELLENCE

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BALANCE / DIZZINESS QUESTIONAIRRE

Name: _____ **Age:**__ **Date of Birth:**___/___/___ **Today's Date:**___/___/___

Referring Physician: _____ **Height:** _____ **Weight:** _____ **Prior patient?** Yes / No

What is your chief complaint (symptoms)? _____

When and how did this first occur? _____

How long did it last or is it ongoing? _____

Have you had this problem before? _____

When did you last experience your symptoms? _____

Have your symptoms? □Improved □Worsened □Stayed the same

Have you had any previous testing or therapy for dizziness / imbalance? Yes / No

If yes, when and where was the testing done? _____

How would you grade the overall severity of your symptoms on your daily function, using a 1-10 scale with 0 being "no limitations" and 10 representing "incapacitated?" (please circle) 1 2 3 4 5 6 7 8 9 10

Have you ever experienced any of the following for minutes or longer? (check all that apply)

□Double vision □Blindness or loss of vision □Slurred speech □Inability to speak or swallow
□Flashes of light □Loss of consciousness □Weakness or numbness on one side (arms, legs or face)

MEDICAL HISTORY: (please check or list any injuries or illness for which you have ever received treatment)

- □ Abnormal heart rhythm
- □ ADD / ADHD
- □ Arthritis
- □ Allergies / Sinus Problems
- □ Alzheimer's / Dementia
- □ Anemia / Blood Disease
- □ Anxiety or Panic Attacks
- □ Autoimmune Disease
- □ Cancer
- □ Cerebral Palsy
- □ Chronic pain
- □ Cleft Palate or Lip
- □ Cytomegalovirus (CMV)
- □ Diabetes
- □ Depression
- □ Glaucoma, Cataract, Macular
- □ Genetic Disorder / Syndrome
- □ Head or Neck Injury
- □ Headaches / Migraine
- □ Heart Disease
- □ Hepatitis (A,B or C)
- □ Herpes
- □ High fever
- □ High Cholesterol
- □ High/Low Blood Pressure
- □ HIV / AIDS
- □ Kidney disease
- □ Liver Disease
- □ Ménière's Disease
- □ Measles or Mumps
- □ Meningitis
- □ Multiple Sclerosis
- □ Neuropathy
- □ Otosclerosis
- □ Parkinson's disease or tremor
- □ Pacemaker
- □ Polio
- □ Rubella
- □ Scarlet fever
- □ Seizure Disorder
- □ Stroke / TIA / CVA
- □ Syphilis
- □ TMJ
- □ Thyroid Disorder
- □ Tuberculosis

OTHER:_____

_____

DIZZINESS / VERTIGO:

Do you have dizziness? □Yes □No *(If no, you may proceed to the next section)*

If you have dizziness, which best describes it? (check all that apply)

□Spinning rotation □Rocking motion □Motion sickness □Head swimming □Floating feeling □Lightheaded
□Poor balance □Sense of falling □Tilting / Leaning □Motion sick □Other: _____

Is your dizziness?

□Continuous □Continuous but periodically worsens □Intermittent or episodic
If episodic, how often? _____ Do you have any warning that the attack is about to start? _____

If you have attacks of dizziness or periods of worsening, when do they occur? (check all that apply)

□When standing up □During weather changes □With head movements □When turning eyes side to side
□In crowded places □Seeing things in motion □When straining or lifting □When exercising
□When hungry □When stressed □When fatigued □With menstruation
□When turning in bed, rolling over or looking up/down □Other: _____

EQUILIBRIUM / BALANCE:

Do you have loss of balance or unsteadiness? □Yes □No *(If no, you may proceed to the next section)*

If you have loss of balance or unsteadiness, which best describes your problem? (check all that apply)

□Off balance only when standing up □Off balance when walking □Off balance when turning
□Off balance when standing, sitting, or lying □Off balance in darkness □Off balance on soft or uneven surfaces
□Environment seems unstable or in motion □Tendency to veer to the side when walking
□Tendency to fall forward/backward □Other: _____

Do you get motion sickness easily (airsick, carsick, or seasick)? □Yes □No

Have you had recent falls? □Yes □No **How many times in the last month?** _____

What caused the fall(s)? _____ **Are you afraid of falling?** □Yes □No

OTOLOGIC HISTORY:

Do you have difficulty hearing? Yes____ No____ **If yes, for how long?**_____

Which Ear? Both____ Left____ Right____ **Is the hearing loss?** Sudden____ Gradual____ Fluctuating____

Does the hearing change with your symptoms? Yes___ No___ **Do you wear hearing aids?** Yes___ No___

Do you have tinnitus (noise in your ears)? Yes____ No____ **If yes, for how long?**_____

Which Ear? Both____ Left____ Right____ **Is the tinnitus?** Constant____ Intermittent____ Pulsing____

Does the tinnitus change with your symptoms? Yes___ No___

Do you have any of the following: (please check Yes or No)

Sudden Hearing Loss?	□Yes □No	When did this occur?
Ear Pain or Fullness?	□Yes □No	Does this change with your symptoms?
Frequent Ear Infections?	□Yes □No	When was most recent?
Discharge / Drainage from Ears?	□Yes □No	Please describe:
Ear Surgery?	□Yes □No	Please describe:
History of Noise Exposure?	□Yes □No	Please describe:
Family History of Hearing Loss?	□Yes □No	Please describe:

SURGICAL HISTORY (please list any surgeries and/or operations that you have had)

_____

_____

_____

MEDICATIONS (please list current medications, what you are taking them for and when you last took them)

_____

_____

_____

_____

_____

NOTES: (PLEASE LEAVE THIS SECTION AND THE REST OF THIS FORM BLANK)

_____

_____

_____

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_____

FDA ref criteria:

1. Visible congenital or traumatic deformity of the ear
2. Hx of active drainage from the ear in previous 90 days
3. Hx of sudden hearing loss or progressive HL within 90 days
4. Acute or chronic dizziness
5. Unilateral HL of sudden or recent onset within 90 days
6. Conductive HL: Audiometric A-B gaps $\geq$ 15dB at 500-2000Hz
7. Visible evidence of impacted cerumen or foreign body in canal
8. Otalgia or ear discomfort

Audiologist Initials: _____

Ref criteria:

1. Otalgia
2. Inflammation of the ear
3. Foul smelling or purulent aural drainage
4. Otitis media
5. Vertigo-Initial evaluation/recent onset
6. Tinnitus-Initial evaluation/recent onset
7. Blocked feeling in ear
8. Balance disturbance
9. Spontaneous nystagmus
10. Symptoms associated with ototoxic drugs
11. Impacted cerumen
12. Neurological evaluation
13. Meniere's disease
14. Asymmetrical hearing loss-Initial evaluation/recent onset
15. Sudden hearing loss initial evaluation/recent onset
16. Perforated tympanic membrane