Neurodiagnostic Information

Center of Specialty Care
The American Institute of Balance

Patient Name: _____ Date of Birth: ____/____/____ Examiner: _____

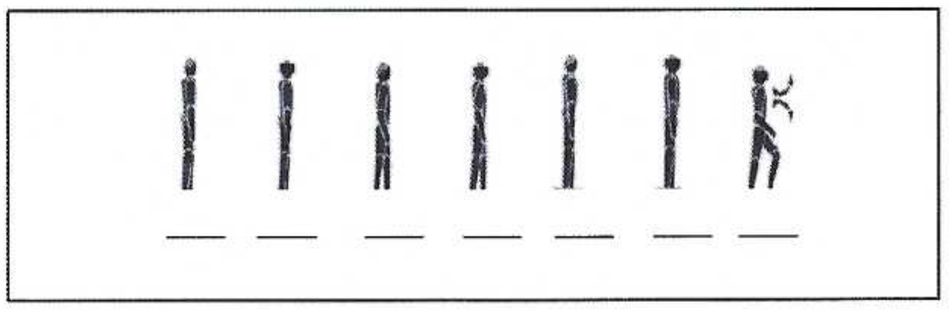
Provider Name: _____ Appointment Date: ____/____/____ Assistive Device: Yes / No

Physician Follow Up: ____/____/____ Sex: Male / Female

Check if Completed

- **GANS SOP Test**

N = Normal
S = Sway
F = Fall
R = Right
L = Left



- **Otoscopy** Unremarkable / Remarkable Notes: _____
- **Electrode Impedance** Good / Poor Notes: _____
- **ABR (Neuro Slow Rate Study)** 95 dB 500 sweeps 3x per ear Notes: _____
- **ECoG** 90 dB 500 sweeps 3x per ear AP (1.5ms) Notes: _____
- **cVEMP** 95 dB 50-100 sweeps 2-3x per ear P (~13ms), N (~23ms) Notes: _____
- **oVEMP**: 95 dB 50-100 sweeps 2-3x per ear N (~10ms), P (~16ms) Notes: _____
- **VNG Calibration** (Cover off): Patient-specific / Default
- **Random Saccades** Notes: _____
- **Smooth Pursuit** Notes: _____
- **Optokinetic** Notes: _____
- **Gaze** (Cover On) Notes: _____
- **Head-Shake:** Dizziness Reported? Yes / No Notes: _____
- **Rotary Chair**: Notes: _____
- **VAST** (Cover off): Positive / Negative If so: Left / Right Notes: Notes: _____
- **Hallpike Right** Dizziness Reported? Yes / No Eye movement? Yes / No Notes: _____
- **Hallpike Left** Dizziness Reported? Yes / No Eye movement? Yes / No Notes: _____
- **Supine** (Cover On): Dizziness Reported? Yes / No Notes: _____
- **Head Right** Dizziness Reported? Yes / No Notes: _____
- **Body Right** Dizziness Reported? Yes / No Notes: _____
- **Head Left** Dizziness Reported? Yes / No Notes: _____
- **Body Left** Dizziness Reported? Yes / No Notes: _____
- **Calorics**: Notes: _____

Additional Testing

- **vHIT** Notes: _____
- **AIB CDVAT** Notes: _____

Other Notes:

When did symptoms first begin?
Date: _____
When was your most recent episode?
Date: _____
How do you describe your dizziness?
- see spinning
- feel spinning
- lightheaded
- imbalance/falls

Are symptoms:
- constant
- attacks

How long do symptoms last?
- seconds
- minutes
- hours
- days

Health Conditions
- peripheral neuropathy
- anxiety / stress
- depression
- motion sickness / intolerance
- cardiac problems
- diabetes
- respiratory problems
- thyroid dysfunction
- high blood pressure
- low blood pressure
- Meniere's disease
- migraine
- orthopedic limitations
- stroke / TIA
- concussion / head injury

Recent Head Imaging? CT / MRI

Did you take any medication for dizziness today? YES / NO

Are you currently in physical therapy? YES / NO
If yes, for what?

_____

Do you have a history of:

• changes in hearing	L R B
• wearing hearing aids	L R B
• fullness in ears	L R B
• ear pain	L R B
• ear drainage	L R B
• ringing in ears	L R B