Audiology & Hearing SOLUTIONS

You have been scheduled for vestibular testing because of dizziness or other balance disorders. **AHS Audiology & Hearing Care is located at 2501 E. Fifth Street across from Posados Mexican Restaurant.** You should check in with the receptionist at our Center, approximately 15 minutes before your scheduled appointment time in order to complete paperwork. The testing will take approximately 3 hours. Please try to have someone accompany you to the test and be available to drive you home, if necessary.

In order to obtain the most valid and accurate results, and for your comfort and protection, you are asked to please comply with the following instructions:

►**Discontinue for 48 hours prior to testing** any anti-vertigo medications, or medications that suppress the vestibular system or affect the central nervous system. These medications include antivert, meclizine, bonine, dramamine, scopolamine, antihistamines, sleeping pills, some pain medications, narcotics, some anti-depressants, or tranquilizers. Both over-the-counter and prescription forms of these medications may adversely affect the test results. **DO NOT DISCONTINUE MEDICATIONS FOR BLOOD PRESSURE CONTROL, CARDIAC OR CIRCULATORY PROBLEMS, DIABETES, OR OTHER MEDICATIONS FOR SIMILAR MEDICAL DISORDERS!** Please feel free to call our Center or your referring physician with questions.

► **Abstain from alcohol 48 hours before the test.**

► **Abstain from caffeine 24 hours before the test, if possible**. Products containing caffeine include soft drinks, coffee, tea, cola and chocolate.

► **If medically possible, abstain from food or liquids 3 hours before the test**. If you are a diabetic, or have a similar disorder, eat a light meal and continue your regular routine.

► You will be asked to **remove glasses and/or contact lens before testing.**

► **Do not wear eye make-up, especially mascara, the day of the test.** Wear loose comfortable clothing and flat healed shoes for the test. You are welcome to bring your make-up with you to apply after the test is completed.

Please Call 903-593-7977 or 1-866-318-0803 between 9:00 am and 4:00 pm if you have any questions about these instructions, such as which medications you can take, when you can eat prior to the test, etc. If you need to reschedule or cancel your appointment, please call at least 24 hours prior to your scheduled appointment.

Please, STOP ALL the following medications / products 2 Days (48 Hours) before testing:

- ► Alcohol
- ► Antihistamines
- ► Antivert
- ► Meclizine
- ► Dramamine
- ► Valium
- ► Ambien
- ► Sleeping Pills
- ► Exelon
- ► Xanax
- ► Pain Medications

Please, STOP the following 1 day (24 hours) before testing:

- ► Caffeine, Soft Drinks, Coffee, Tea Chocolate, etc.
- ► Aspirin

Please, CONTINUE the following medications for the following conditions:

- ► Blood Pressure
- ► Heart Medications
- ► Cholesterol
- ► Diabetes

If you any questions or doubt about stopping any medication before testing, please contact **AHS Audiology & Hearing Care at 903-593-7977** or call your referring physician for clarification.

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PATIENT INTAKE FORM

PATIENT NAME: _____ SEX: ☐ M ☐ F

DOB: _____ AGE: _____ SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ CELL #: _____

PRIMARY PHYSICIAN: _____ PHYSICIAN PHONE: _____

Does your medical history include any of the following:

☐ **Surgery**
☐ **Chronic or Migraine Headaches**
☐ **Diabetes**
☐ **Respiratory Problems**
☐ **Hypertension**
☐ **Circulatory Problems**
☐ **Fatigue**
☐ **Other:** _____
☐ **Cardiac Problems**
☐ **Current Medications:** _____

_____

Other Factors:

☐ **New Glasses**
☐ **Ringing/Noises in Ears**
☐ **Hearing Problems**
☐ **Fullness/Pressure in Ears**

When did your dizzy/balance problem first occur: _____

_____

Do any activities or head/body movements trigger the problem or make it worse? ☐ **Yes** ☐ **No**

If yes, please explain: _____

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INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____

POLICY HOLDER: _____ DOB: _____

SECONDARY INSURANCE: _____ ID #: _____

POLICY HOLDER: _____ DOB: _____

If no medical insurance is available, payment is expected at the time of service unless other arrangements have been made. I hereby authorize AHS Audiology & Hearing Care to use this form on all insurance submissions and the release of information to all insurance carriers.

I give permission for AHS Audiology & Hearing Care to request medical information from my physician in order to aid in the evaluation and interpretation of test results. Furthermore, I give permission to AHS Audiology & Hearing Care to release test results and recommendations to my referring physician, and to any other physician for which I give permission.

I give permission to be tested at AHS Audiology & Hearing Care. I have been informed that I will have audiologic and vestibular testing, which may include electronystagmography with calorics, auditory brainstem response testing, and otoacoustic emissions testing.

I acknowledge that I have read and understand the above statements. I attest that the information I have provided is true and correct to the best of my ability.

PATIENT SIGNATURE (OR GUARDIAN): _____

DATE: _____