VERNICK & GOPAL
HEARING CENTER
1244 BOYLSTON ST. SUITE 303
CHESTNUT HILL, MA 02467
Office # 617-383-6830 Fax # 617-383-6880

Dix Hallpike/Epley Maneuver Instructions

I. Appointment

You have been scheduled for a Dix Hallpike/Epley Maneuver on _____at_____. The procedure will take approximately 30-45 minutes.

II. Description

During the maneuver, you will be asked to wear a pair of goggles which will track a particular eye movement called nystagmus. The presence, direction, speed and timing of the nystagmus are useful in your treatment. Although some people experience a little dizziness during the test, the dizziness is of short duration, and by procedure completion, all signs of dizziness have usually subsided.

III. Preparation

1. **You should not consume any food or beverages of any kind one hour before the test. Make any meal prior to the procedure a small one, e.g. for breakfast have juice and a piece of toast.**
2. Do not wear make-up.
3. Remove contact lenses prior to testing.
4. Wear comfortable clothes. You will be asked to move in a variety of positions on an examining table.
5. You will be asked to remove your shoes prior to testing.

IV. Homework

Please answer the questions attached to this form and bring the completed form with you to your appointment. We look forward to seeing you.

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Patient Name:_____ SSIMED #_____(office use)

Appointment date/time:_____

Dix Hall Pike Questionnaire

I. "Dizziness" means different things to different people. Please describe your dizziness in detail. Most patients can remember the initial episode best, please describe that episode.

_____
_____

II. When did the dizziness start and what were you doing when it first began?

_____
_____

III. Does the dizziness come in episodes or is it constant? How long does each episode last?

_____
_____

IV. How often do you have an attack?

_____
_____

V. Do you get a warning of impeding dizziness? If so, how can you tell you are about to experience dizziness?

_____
_____

VI. Is there anything you can do to lessen the severity of an attack or stop it entirely? If so, what?

_____
_____

VII. Is there anything you do that seems to bring on an attack of dizziness? If so, what?

_____
_____

VIII. List any other health problems you are having.

_____
_____
_____

IX. What do you think is the cause of your dizziness?

_____
_____
_____

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Medication Form

Patient's Name: _____
D.O.B. _____
SSIMED # _____
Date of Service: _____

Drug / Medication Information

List all medications you are currently taking: Include prescription drugs, inhalers, aspirin products, non-steroidal anti-inflammatories, eye drops, herbal supplements, nutritional supplements, vitamins, over-the-counter medications and non-prescription drugs.

Medication/Drug Name	Dose	Frequency	When You Last Took Medication

Please list any known allergies:

_____
_____
_____