

Delaware Superior Canal Dehiscence History and Exam Checklist

Name: _____ DOB: _____ Sex: M / F

Date 1st seen: _____

Approximate date of 1st symptoms: _____

Trauma Y/N If yes, baro/physical/acoustic
Side L/R/bil

Symptoms:

Hyperacusis: Y/N
Tullio: Y/N
Autophony: Y/N
Hearing loss: Y/N
Pulsatile tinnitus: Y/N
Fullness: Y/N
Tinnitus: Y/N
Chronic disequilibrium: Y/N
Vertigo: Y/N

Signs:

Valsalva-induced symptoms Y/N
Valsalva-induced eye mvmts Y/N
Sound-induced symptoms Y/N Barany Best Frequency
Sound-induced eye mvmts Y/N Barany Best Frequency
Weber head R/L/M
Weber ankle R/L/M/neg
Head thrust positive SCC Y/N
Tragal compression symptoms Y/N
Tragal compression eye mvmts Y/N
Ear insufflation symptoms Y/N
Ear insufflation eye mvmts Y/N
Vibration-induced symptoms Y/N
Vibration-induced eye mvmts Y/N

Testing:

Audiogram

Suprathreshold? Y/N
Conductive HL? Y/N PTA air _____ bone _____
Sensorineural HL? Y/N
Tympanogram normal? Y/N

Other _____

CT scan

Positive right Y/N
Positive left Y/N

Slice thickness _____
Proper format? _____ Y/N

cVEMP/oVEMP click/tone stimulus
Threshold right _____
Threshold left _____
Amplitude right _____
Amplitude left _____

EcOG SP/AP R _____ L _____

Concurrent disease
Migraine Y/N
Hydrops Y/N

Medical treatments performed _____

Surgical treatments performed _____