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______________________________________

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