dr. louis hofmeyr

SUPERIOR CANAL DEHISCENCE(SCD) QUESTIONNAIRE

Name_____ Date_____

Instructions

1. Complete this questionnaire by marking the applicable block.
2. Scale your symptoms from 1 to 5 where:
    a. 1 means you are not bothered at all by the symptoms.
    b. 5 means you are completely disabled by the symptoms.
3. The following scale is not verified but can help to monitor the response on treatment.

	Symptom	1	2	3	4	5
1	Hearing your own voice in the affected ear					
2	Hearing your own footsteps, eye movements or breathing in the affected ear					
3	Hearing your own heartbeat in the affected ear					
4	Loud sounds causes dizziness					
5	Straining or lifting heavy objects causes dizziness					
6	Nose blowing or equelizing the ears causes dizziness					
7	Hearing loss in the affected ear					
8	Pressure and fullness in the affected ear					
9	General disequilibrium/ imbalance					

Adapted from

Silverstein H, Kartush JM, Parnes LS, Poe DS, Babu SC, Levenson MC, Wazen J and Ridley RW. Round window reinforcement for superior semicircular canal dehiscence: A retrospective multi-center case series. *AMERICAN JOURNAL OF OTOLARYNGOLOGY–HEAD AND NECK MEDICINE AND SURGERY.*2014;35:286–293.

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