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OTOLARYNGOLOGY- HEAD & NECK SURGERY

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Instructions for Video-Electronystagmography (VNG) Testing

You have been scheduled to undergo tests ordered by your physician to help determine the cause of your dizziness and/or vertigo. Your appointment should last approximately 1 hour. The tests are designed to evaluate the different components of your balance system. During the testing and potentially after the testing, you may experience a sensation of motion or unsteadiness. There should be no long term effect on you from this testing. If possible we encourage you to have someone accompany you to and from the appointment, however if this is not possible try to plan an extra 15-20 minutes after your test before you leave the office.

Once your evaluation is complete each part will be carefully reviewed. An interpretation of the results will be made and a thorough report will be given to your physician. Most balance problems can be treated medically, surgically or with therapy once an appropriate diagnosis can be made. Vestibular and/or Balance therapy has been shown to reduce or eliminate dizziness, vertigo, and unsteadiness in many patients.

Please refrain from taking certain medications for **48 HOURS** prior to your test date. Some medications can influence the body's response to the test and give a false test result. There is a short list of medications below, however **always consult with your physician first before discontinuing any prescribed medications.**

- **Analgesics – Narcotics:** Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet
- **Anti-histamines:** Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin or any other over-the-counter cold medicines
- **Anti-seizure medicine:** Dilantin, Tegretol, Phenobarbital
- **Anti-vertigo medicine:** Antivert, Ruvert, Meclizine
- **Anti-nausea medicine:** Atarax, Bonine, Bucladin, Compazine, Dramamine, Phenergan, Scopalomine, Therazine, Transdermal
- **Sedatives:** Dalmane, Halcion, Nembutal, Testoril, Seconal, Ambien, Lunesta or any sleeping pill
- **Tranquilizers:** Atarax, Ativan, Librium, Librax, Serax, Tranxene, Valium, Vistaril, Xanex

You may take blood pressure medications, heart medications, thyroid medication, Tylenol, insulin, estrogen, etc.

1. **Please DO NOT wear eye makeup (mascara, eye liner, eye shadow, etc.)**
2. **Please eat lightly for 12 hours prior to your appointment, avoiding caffeine in beverages such as coffee or soft drinks.**
3. **Please DO NOT smoke 12 hours prior to testing.**
4. **Please DO NOT drink alcoholic beverages within 48 hours of the testing.**
5. **If you wear contact lenses, please refrain from wearing them during the testing and bring your distance glasses with you.**

PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE:_____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____
How long did it last? _____

1. **Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.**

YES NO

☐ ☐ Do you experience motion sickness?
☐ ☐ Do you have migraine headaches?
☐ ☐ Did you have any injuries to your head? When? _____
☐ ☐ If you received a head injury, were you unconscious?
☐ ☐ Have you ever had a neck injury?
☐ ☐ Have you ever fallen? How many times? _____
Where? _____ Inside the home? _____ Outside the home? _____
☐ ☐ Are you afraid of falling?
☐ ☐ Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid) What? _____
_____

2. **If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to section 3.**

YES NO

☐ ☐ My dizziness is constant? If you answered yes, please go to section 3.
☐ ☐ If in attacks, how often? _____
☐ ☐ Are you completely free of dizziness between attacks?
☐ ☐ Do you have any warning that the attack is about to start? _____
☐ ☐ Is the dizziness provoked by head/body movement?
If so, which direction?_____
☐ ☐ Is the dizziness better or worse at any particular time of the day?_____
☐ ☐ Do you know of anything that will stop your dizziness or make it better?
What? _____
☐ ☐ Do you know of anything that will make your dizziness worse?_____
☐ ☐ Do you know of anything that will precipitate an attack?
What? _____
☐ ☐ Do you know any possible cause of your dizziness?_____

3. **Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.**

YES NO

☐ ☐ Light headedness?
☐ ☐ Swimming sensations in the head?
☐ ☐ Blacking out or loss of consciousness?
☐ ☐ Objects spinning or turning around you?
☐ ☐ Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐ ☐ Tendency to fall to the right or left?
☐ ☐ Tendency to fall forward or backward?

☐ ☐ Loss of balance when walking, veering to the right?
☐ ☐ Loss of balance when walking, veering to the left?
☐ ☐ Do you have trouble walking in the dark?
☐ ☐ Do you have problems turning to one side or the other?
☐ ☐ Nausea or vomiting?
☐ ☐ Pressure in the head?

4. **Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.**

YES NO

☐ ☐ Double vision? Constant In Episodes
☐ ☐ Blurred vision or blindness? Constant In Episodes
☐ ☐ Spots before your eyes? Constant In Episodes
☐ ☐ Numbness of face, arms or legs? Constant In Episodes
☐ ☐ Weakness in arms or legs? Constant In Episodes
☐ ☐ Confusion or loss of consciousness? Constant In Episodes
☐ ☐ Difficulty in swallowing? Constant In Episodes
☐ ☐ Tingling around the mouth? Constant In Episodes
☐ ☐ Difficulty speaking? Constant In Episodes

5. **Do you have any of the following symptoms? Please check the box for either YES or NO and circle the ear involved.**

YES NO

☐ ☐ Difficulty in hearing? Both Ears Right Ear Left Ear
☐ ☐ Noise in your ears? Both Ears Right Ear Left Ear
Describe the noise? _____
☐ ☐ Does anything stop the noise or make it better? _____
☐ ☐ Fullness or stuffiness in your ears? Both Ears Right Ear Left Ear
Does this change when you are dizzy? _____
☐ ☐ Pain in your ears? Both Ears Right Ear Left Ear
☐ ☐ Discharge from your ears? Both Ears Right Ear Left Ear

Please use the space below to fill in any additional information that you think would be useful in your dizzy/balance assessment.

_____
_____
_____
_____
_____
_____
_____