WHC
WORTH HEARING CENTER

Your appointment is scheduled for _____

What to expect:

Video Nystagmography (VNG) is a test of your balance system. During the test you will be wearing goggles which allow for the recording of your eye movements. The test is painless.

The test consists of 3 parts. First, you will be asked to watch a light as it moves. Next, you will be asked to turn your head in different positions. Finally, cool and warm air will be blown into your outer ear canals while we measure your eye movements. The complete test takes approximately one hour.

VERY IMPORTANT

You must avoid taking certain medications for 48 hours prior to testing. Certain medications interfere with the results of your test**. Please ask if there are any questions about what medications you should and should not take prior to testing.**

Do not take any of the following:

Alcohol in any form

Sleeping pills or any type of Sedative

Anti-dizzy medications or patches

Narcotics or strong pain medications

Tranquilizers and muscle relaxants

Cold or allergy medications

Medications for depression and anxiety

It can be dangerous to abruptly stop taking certain medications. If you are taking any prescription medications that are listed above, please contact your physician regarding how to safely discontinue or taper off the medication prior to the test. If this is not advised, we will document the medication and probably still be able to complete the test. Please note: DO NOT stop taking essential medications such as those for heart disease, diabetes, blood pressure or seizure control.

Also: Avoid caffeinated beverages and tobacco use the day of the test.

Some people feel dizzy during this testing so you may want to skip the meal prior to the test or eat lightly.

Do not wear eye or face make-up.

Wear comfortable clothing.

Patient Name_____ Date_____

Dizziness Questionnaire

Please answer all of the following questions by circling the appropriate responses or by filling in relevant blanks.

CHARACTERIZE YOUR DIZZINESS

Yes No 1. Light Headedness, faintness, giddiness
Yes No 2. Unsteadiness.
Yes No 3. I or my surroundings seem to be moving.
Yes No 4. I am able to go on with my usual activities while dizzy.
Yes No 5. I am able to go on with only some of my usual activities while dizzy.
Yes No 6. I am completely incapacitated and must go to bed while dizzy.

ONSET AND COURSE

7. Date of first dizziness _____
Yes No 8. My dizziness is constant.
Yes No 9. My dizziness comes in attacks.
10. If in attacks, how often? Hourly Daily Weekly Monthly (circle one)
11. How long do they last? Seconds Minutes Hours Days (circle One)
Yes No 12. My dizziness comes on suddenly.
Yes No 13. My Dizziness comes on gradually.
Yes No 14. I am completely free of dizziness between attacks.
Yes No 15. I can tell when an attack is about to start
If Yes Describe how_____

ASSOCIATED SYMPTOMS

Yes No 16. Nausea or vomiting?
Yes No 17. Sweating?
Yes No 18. Deafness or difficulty hearing? Right ear Left ear Both ears (circle one)
Yes No 19. Any Noises (buzzing or ringing) Right ear Left ear Both ears (circle one)
Yes No 20. Change in this noise with dizziness?

Yes No 21. Fullness or pain in ears? Right ear Left ear Both ears (circle one)
Yes No 22. Drainage from ears? Right ear Left ear Both ears (circle one)
Yes No 23. Tendency to fall? Right Left Either (circle one)
Yes No 24. Tendency to veer when walking? Right Left Either (circle one)
Yes No 25. Headache or pressure in head? During After (circle one)
Where?_____
Yes No 26. Double vision, blurred vison or blindness?
Yes No 27. Weakness or clumsiness in arms or legs?
Yes No 28. Difficulty with speech or swallowing?
Yes No 29. Blackouts, loss of consciousness, confusion of loss of memory?
Yes No 30. Rapid heartbeat or palpitations?
Yes No 31. Shortness of breath during the attack?
Yes No 32. Numbness or tingling of face, fingers or toes?
Yes No 33. Pain or stiffness of the neck?

EXACERBATING AND REMITTING FACTORS

Yes No 34. Does turning your head bring on or make your dizziness worse?
Yes No 35. Does lying down or sitting up bring on your dizziness?
Yes No 36. Sowa standing up bring on your dizziness?
Yes No 37. Do you find it especially difficult to walk in the dark?
Yes No 38. Is there any relationship between your dizziness and tension or anxiety in your life? Explain_____
Yes No 39. Do you know of anything that will precipitate an attack?
What? _____
Yes No 40. Do you know of anything that will stop or make you dizziness better?
What? _____

PRESENT/ PAST MEDICAL HISTORY

Yes No 41. Have you ever had a concussion, shull fracture, or been knocked Unconscious?

Yes No 42. Have you ever had a whiplash or do you have a neck disease?

Yes No 43. Do you have an eye disorder or wear glasses?

Yes No 44. Have you ever had ear infections or other ear disease?

Yes No 45. Had you been taking prescription or nonprescription medications Regularly before your dizziness started?
If so, list them. _____

Yes No 46. Do you have any allergies?
If Yes, to what?_____

Yes No 47. Have you in the past or do you now smoke?
Packs per day _____ Years _____

Yes No 48. Have you in the past or are you now a heavy drinker?

Yes No 49. Have you in the past or do you now have
__ Diabetes ___ High blood pressure ___ Migraines ___ Seizers
___ Cancer ___ Stroke ___ Heart Attack

Yes No 50. Do you know of any possible cause of your dizziness?
What_____

Yes No 51. Has another doctor done tests to evaluate your dizziness?
Dr._____ Phone_____ Date_____

Yes No 52. Do you wear an intracardiac catheter or pacemaker with exposed leads?