

Pre-Test Instructions for Videonystagmography (VNG)

You were referred to our clinic because you have spoken to your doctor about your symptoms of dizziness, lightheadedness, and/or unsteadiness. A VNG is a test that focuses on your dizziness/vertigo that can be caused by a disturbance in a particular part of your inner ear of balance system. This test is not painful, however it is time consuming (approximately 1 to 1 ½ hours), so please be prompt.

You must have a driver to escort you to and from this appointment as dizziness, lightheadedness, nausea, and vertigo have been reported by some patients as lingering effects of the vestibular testing. Without a driver you will not be able to complete testing unless you sign our VNG Escort Waiver.

Please be sure to eat a light breakfast/lunch prior to your testing time. Please follow the instructions below. Failure to follow the instructions can cause your test to be inconclusive and/or inaccurate.

1. **DO NOT** wear any make-up the day of your test. This includes **eyelash extensions**, eye shadow, eye liner, mascara, and foundation/powder.
2. **DO NOT** take any of the following at least 48 hours (preferable 72 hours) before the test:
 - Anti-nausea medications: Dramamine, Campazine, Bonine, Marezine, Vontrol, Phenergan, Thorazine, etc...
 - Anti-vertigo medications: Meclizine, Antivert, Ru-vert, etc...
 - Tranquilizers: Valium, Librium, Atarax, Vistral, Equanil, Miltown, Traivil, Serax, Strafon, etc....
 - Sedatives: Nembutal, Seconal, Delmane, Doriden, Placidyl, Quaalude, Butisol, or any other sleeping pill
 - Narcotics and Barbiturates: Pheobarbital, Codeine, Demerol, Dilaudid Percodan, Phenaphen, etc...
 - Anti-Histamines: Chlor-trimeton, Dimetane, Disphorol, Benadryl, Actified, Teldrin, Triaminid, Drixerol, Dimetapp, and/or any over the counter remedies
 - Alcohol: any quantity, including beer, wine, and cough medicines containing alcohol
3. **DO NOT** drink any caffeinated beverages (coffee, tea, colas, cocoa, etc...) for at least 8 hours prior to testing.
4. **DO NOT** smoke for at least 8 hours prior to testing

If you have any questions, please feel free to contact us at 443-295-7100.



Waldorf Diagnostic Hearing & Balance Center
3475 Leonardtown Road, Suite 102, Waldorf, MD
(P) (443) 295-7100 (F) (301) 374-8432
www.freedomhearing.com

Name: _____ Date: _____

Referring Physician: _____

Primary Care Physician: _____

Please answer all of the following questions to the best of your ability

Do you experience any of the following sensations (check any that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Swimming sensation in head | <input type="checkbox"/> Blacking out |
| <input type="checkbox"/> Tendency to fall | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Objects spinning around you | <input type="checkbox"/> Motion sickness |
| <input type="checkbox"/> Pressure in head | <input type="checkbox"/> Loss of balance when walking | <input type="checkbox"/> Fear of falling |

Please select YES or NO and write your answers

Is your dizziness constant? ☐ Yes ☐ No

How often does your dizziness last? _____

How long do your symptoms last? _____

When did you first experience your symptoms? _____

When was your last episode? _____

Did you ever injure your head? ☐ Yes ☐ No

If yes, please explain

Have you had any recent imaging studies (MRI/CT) completed? ☐ Yes ☐ No

If yes, please explain

Is there any relationship between eating and dizziness? ☐ Yes ☐ No

Can you tell when an attack is about to start? ☐ Yes ☐ No

Do you know of anything that makes your dizziness worse or better? ☐ Yes ☐ No

Worse? _____ Better? _____



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How severe is your dizziness (check any that apply)?

- | | | |
|---|--|---|
| <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Getting Better | <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same |

Do you experience any of the following symptoms? Please check box and select the appropriate occurrence.

- | | | |
|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Blurred Vision/Blindness | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Numbness in face | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Numbness in arms/legs | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Weakness in arms/legs | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Clumsiness in arms/legs | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Confusion or loss of consciousness | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Difficulty with speech | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Constant | <input type="checkbox"/> In Episodes |