FREEDOM Hearing Center LLC

Waldorf Diagnostic Hearing & Balance Center
3475 Leonardtown Road, Suite 102, Waldorf, MD

(P) (443) 295-7100    (F) (301) 374-8432
www.freedomhearing.com

## 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 [illegible].**

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, Vistrail, Equanil, Miltown, Traivil, Serax, Strafon, etc….
    - Sedatives: Nembural, 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.**

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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):***

| | | |
|---|---|---|
| ☐ Lightheadedness | ☐ Swimming sensation in head | ☐ Blacking out |
| ☐ Tendency to fall | ☐ Loss of consciousness | ☐ Migraines |
| ☐ Nausea/vomiting | ☐ Objects spinning around you | ☐ Motion sickness |
| ☐ Pressure in head | ☐ Loss of balance when walking | ☐ 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)?

| | | |
|---|---|---|
| ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Getting Better | ☐ Getting Worse | ☐ Staying the Same |

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

| | | |
|---|---|---|
| ☐ Double Vision | ☐ Constant | ☐ In Episodes |
| ☐ Blurred Vision/Blindness | ☐ Constant | ☐ In Episodes |
| ☐ Numbness in face | ☐ Constant | ☐ In Episodes |
| ☐ Numbness in arms/legs | ☐ Constant | ☐ In Episodes |
| ☐ Weakness in arms/legs | ☐ Constant | ☐ In Episodes |
| ☐ Clumsiness in arms/legs | ☐ Constant | ☐ In Episodes |
| ☐ Confusion or loss of consciousness | ☐ Constant | ☐ In Episodes |
| ☐ Difficulty with speech | ☐ Constant | ☐ In Episodes |
| ☐ Difficulty swallowing | ☐ Constant | ☐ In Episodes |