



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 1/2 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.** 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 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:

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Email: gdiatzfreedomhearing@gmail.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 circle 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? _____

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 circle the occurrence?

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