BREVARD EAR, NOSE, & THROAT CENTER

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Pre-Test Instructions for Videonystagmography (VNG)

Videonystagmography is used to evaluate patients with dizziness, vertigo, or balance dysfunction.

Name _____

Time_____ **Date**_____

The VNG takes about one hour to complete. Some dizziness is normal during testing, however it is usually short in duration. It is advised to have someone drive you home.

You will be wearing goggles for the entire test, so it is important to have a clean face with no makeup, **especially no eye makeup,** on the day of your VNG.

Certain substances may interfere with our testing. Please refrain from taking the following **48 hours prior to the test;**

*Alcohol
*Caffeine
*Anti-dizzy Medications (Meclizine, Bonine, Antivert, Dramamine Scopolamin, etc)
*Narcotics or Barbituates (Codeine, Demerol, Percodan, Hydrocodone,Vicodin, etc)
*Antihistamines or other over-the-counter cold remedies
*Sleeping pills, sedatives, tranquilizers, or muscle relaxants

DO NOT stop taking medications for high blood pressure, diabetes, seizures, or any other medications deemed necessary by your physician. All medications can be resumed immediately after completing the VNG. Please consult our office with questions concerning your medications.

You will be more comfortable on an empty stomach as we may make you dizzy during the test. We suggest not eating for four hours prior to testing. Please refrain from smoking for four hours before testing.

Please call us at (321) 632-6900 with any questions.

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DIZZINESS QUESTIONNAIRE

NAME_____DATE_____

1. When you are "dizzy" 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	
❑	❑	1. Lightheadedness
❑	❑	2. Swimming sensation in the head
❑	❑	3. Blacking out
❑	❑	4. Loss of consciousness
❑	❑	5. Tendency to fall: To the right?
❑	❑	To the left?
❑	❑	Forward?
❑	❑	Backward?
❑	❑	6. Objects spinning or turning around you.
❑	❑	7. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
❑	❑	8. Loss of balance when walking: Veering to the right?
❑	❑	Veering to the left?
❑	❑	9. Headache
❑	❑	10. Nausea or vomiting
❑	❑	11. Pressure in the head

II. Please check box for either YES or NO and fill in the blank spaces.

YES	NO	
❑	❑	1. My dizziness is constant?
❑	❑	in attacks?
		2. When did dizziness first occur?_____
		3. If in attacks: How often?_____
		How long do they last?_____
❑	❑	Do you have any warning the attack is about to start?
❑	❑	4. Are you completely free of dizziness between attacks?
❑	❑	5. Does dizziness occur only in certain positions?
❑	❑	6. Do you have trouble walking in the dark?
❑	❑	7. When you are dizzy, must you support yourself when standing?
❑	❑	8. Do you know of any possible cause of your dizziness?
		What?_____
		9. Do you know of anything that will:
❑	❑	Stop your dizziness or make it better?
❑	❑	Make your dizziness worse?
❑	❑	Precipitate an attack?
❑	❑	10. Were you exposed to irritating fumes, paints, etc at the onset of dizziness?
❑	❑	11. Do you have any allergies?

❑	❑	12. Did you ever injure your head?
❑	❑	Were you unconscious?
❑	❑	13. Do you take any medications regularly (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics?) What?_____
❑	❑	14. Do you use tobacco in any form? How much?_____
❑	❑	15. Do you use alcohol?
❑	❑	16. Have you ever had ear surgery?

III. Do you have any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle the ear involved.

YES	NO				
❑	❑	1. Difficulty in hearing	Both ears	Right	Left
		When did this start?_____			
❑	❑	Is it getting worse?			
❑	❑	2. Noise in your ears?	Both ears	Right	Left
		Describe the noise_____			
❑	❑	Does noise change with dizziness?			
		If so, how?_____			
❑	❑	Does anything stop the noise or make it better?			
❑	❑	3. Fullness or stuffiness in your ears?	Both ears	Right	Left
❑	❑	Does this change when you are dizzy?			
❑	❑	4. Pain in your ears?	Both ears	Right	Left
❑	❑	5. Discharge from your ears?	Both ears	Right	Left

IV. Have you ever experienced any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle if Constant or if In Episodes.

YES	NO			
❑	❑	1. Double vision	Constant	In Episodes
❑	❑	2. Numbness of face or extremities	Constant	In Episodes
❑	❑	3. Blurred vision or blindness	Constant	In Episodes
❑	❑	4. Weakness in arms or legs	Constant	In Episodes
❑	❑	5. Clumsiness in arms or legs	Constant	In Episodes
❑	❑	6. Confusion or loss of consciousness	Constant	In Episodes
❑	❑	7. Difficulty with speech	Constant	In Episodes
❑	❑	8. Difficulty with swallowing	Constant	In Episodes
❑	❑	9. Tingling around the mouth	Constant	In Episodes
❑	❑	10. Spots before the eyes	Constant	In Episodes

V. Please check box for either YES or NO.

YES	NO	
❑	❑	1. Do you get dizzy after exertion or overwork?
❑	❑	2. Did you get new glasses recently?
❑	❑	3. Do you tend to get upset easily?
❑	❑	4. Do you get dizzy when you have not eaten for a long time?
❑	❑	5. Is your dizziness connected with your menstrual period?
❑	❑	6. Have you ever had a neck injury?