ADVANCED EAR, NOSE & THROAT ASSOCIATES, P.C.
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Electronystagmogram (ENG)
Videonystagmogram (VNG)

The purpose of this test is to help your physician determine the cause of your dizziness, vertigo or balance problem.

Procedure: This is a non-invasive procedure in which video goggles will be placed over your eyes or electrodes may be adhered to your skin. You will be sitting and lying down during testing. Your eyes will be recorded while you track some moving lights and while you turn your head in various positions. Cool and warm water will be placed in your ears while you are lying comfortably. This may cause a brief dizziness which will subside quickly.

∗ At the time of your test please let your examiner know if you cannot have water in your ears and this part of the test will not be done.

Pre-Test Instructions:

- Do not take sedating medications for 48 hours prior to testing. These include antihistamines, Meclizine, Antivert, sleeping pills, tranquilizers, narcotic pain medications (i.e. hydrocodone, Vicoden) or alcohol for 48 hours.
- **Essential medications, such as for blood pressure, diabetes, or heart should be taken.** Take all of your regular medications except those listed in the prior paragraph. Always ask your physician if you are not sure whether it is safe to stop taking a medication.
- No food or drink **3 hours** prior to testing. If you are diabetic, you may eat something light **2 hours** before the test as needed.
- Contact lenses should not be worn.
- Do not wear facial make-up since it interferes with the electrodes and video goggles.
- Please arrange for transportation home after the test, as you may experience more dizziness for a short period after the test.

*** If unable to keep this appointment, please cancel 24 hours prior to the appointment. Failure to do so will result in a $200 No Show Fee.**

VESTIBULAR QUESTIONNAIRE

Appt Date: __________

Name ____ Age __________ Height ________ Weight __________

What is your worst symptom? ____

When did it start? _________ Have you had this problem before? __________________________________

When? ____

<u>Past Medical History</u> (circle those that apply now or in the past):

hearing loss	severe headaches	epilepsy	IV antibiotic treatment
Meniere's disease	panic attacks	stroke	high blood pressure
cardiac problems	carsickness	joint replacement	osteoarthritis
pacemaker	spine surgery/injury	visual loss	rheumatoid arthritis
diabetes	multiple sclerosis	serious head trauma	osteoporosis
surgery	asthma	Parkinson's disease	cancer
ear surgery	ruptured ear drum	hole in ear drum	chronic ear infection

Other: ____

Current Medications: ____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Allergies: ____

Family History (circle those that apply):

deafness	dizziness vertigo	carsickness	Meniere's
imbalance	severe headaches	panic attack	depression

Which best describes your dizziness? (circle those that apply)

spinning/rotation	floating	rocking motion	tilting
head fullness	free falling	poor balance	motion sickness
nausea	feel that you may fall		

Other: ____

If you have imbalance, which describes the problem?

loss of equilibrium	environment seems unstable or in motion
off balance only when standing	off balance standing, sitting or lying down

Is your dizziness:

intermittent continuous continuous, but periodically worsens

When you have dizziness, how long does it last? (circle those that apply)

continuous	seconds (<1 minute)	1-5 min.	5-20 min.	20 min. - 3 hrs.
> 3 hrs.	days	weeks	months	years

Rate intensity of dizziness on a scale 0-10:

Baseline Now ___________ Average day recently ___________ Peak attack ___________

If you have attacks of dizziness or periods of worsening, when do they occur ?(circle those that apply)

turning in bed, rolling over, looking up	with menstruation
seeing things in motion	hunger
no particular pattern	stress
with head movement	weather changes
turning eyes side to side	in crowed places
with fatigue	standing up from bed/chair
walking	bending over

Other: ____

Have you ever had several minutes of:

double vision	slurred speech	weakness/numbness on one side
blindness	flashes of light/zigzag lines	inability to speak

My illness/injury/surgery interferes with my normal activities (work, leisure, activities of daily living):

Not at all A little bit Moderately Quite a bit Extremely

Are you unable to:

work	drive a car	grocery shop	go in a mall or theater
ride elevators	ride in a car	walk	walk on unstable surfaces

Home Environment: (circle all that apply)

live alone	live with someone who can/does assist me	single parent
live with children	live with ill/disabled family member	other

Do you use an assistive device for walking, such as a cane or walker? Yes No

If so, what: ____

Please list 3 things that are difficult to do because of your current condition and 3 goals you would like to work on.

Difficult things to do:

1. ____
2. ____
3. ____

Goals:

1. ____
2. ____
3. ____

Provider Notes:

Audiologist: