



INSTRUCTIONS FOR VIDEONYSTAGMOGRAPHY (VNG)

The VNG is a group of tests looking at the balance functions of the inner ear and brain which provides information about the source of your dizziness or unsteadiness. We schedule 2 hours for the test, however, it may take as little as 1 hour to complete. Many people experience some dizziness during the test however, it usually does not last long. It is therefore, **strongly recommended** that a relative or friend drive you home following the test. It is also, **strongly recommended that if you have a cane or walker, even if you only use it occasionally, that you bring it to the appointment.** Again, this is because many people experience an increase in dizziness. To record any dizziness experienced throughout the test you will be looking through lightweight goggles equipped with miniature video cameras.

Instructions for testing:

1. Avoid wearing make-up, especially eye make-up.
2. Wear Comfortable clothing and flat shoes.
3. Eat only a light meal at least 2 hours prior to the testing.
4. **Please do not take any of the following medications/substances for 48 hours prior to testing.** These substances can influence the body's response to this test and give false responses.

Alcohol

Allergy Medicine

Anti-Histamines

Anti-Nausea Medicine

Anti-Vertigo Medicine (Meclizine/Antivert)

Caffeine

Cough Syrup

Sedatives

Tranquilizers

Please continue taking any medications for your heart, blood pressure, diabetes, seizures, etc.

If you have any questions prior to testing, please contact Healthy Hearing and Balance at 410-857-3800.



Patient Name: _____ Date _____
Completed: _____

DIZZINESS QUESTIONNAIRE

When you are “dizzy” do you experience any of the following sensations/symptoms?

Please check all that apply.

- Spinning
- Lightheadedness
- Swimming sensation in the head
- Black out/Loss of consciousness
- Hearing Loss
- Headache
- Tinnitus (noise in the head/ears)
- Full feeling in the ear(s)
- Nausea/vomiting
- Pressure in the head
- Sensitivity to light/noise
- Tendency to fall, **please specify:** __right __left __forward __backward

Describe your “dizziness” attack(s).

Is your dizziness constant or in attacks? _____

When did the first attack occur? _____

How long since your last attack? _____

How often do the attacks occur? _____

How long do they last? _____

What, if any, warning signs do you have before an attack? _____

Does dizziness occur in certain body/head positions? _____

Are you completely free of dizziness between attacks? _____

Do you know of any possible causes for your dizziness? _____

Do you know of anything that will stop your dizziness or make it worse? _____

Were you exposed to any irritating fumes, paints, etc at the onset of your dizziness? _____

Health questions. Please check all that apply.

- Have you ever had ear surgery?
- Difficulty with hearing?
- Fluctuating hearing loss?
- Pain/Discharge in ears?
- Have you ever been exposed to or work in loud noise?
- Do you have any allergies?
- Do you use tobacco?
- Do you use alcohol?
- Do you or have you ever had cold sores/shingles/Herpes Simplex virus?
- Do you have autoimmune issues such as Rheumatoid Arthritis?
- Do you have acute ear/sinus infections?
- Do you have Diabetes?
- Do you have high or low blood pressure?

What brings on your dizziness? Please check all that apply.

- Did you recently get new glasses/contacts?

- 🍏 Do you get dizzy if you miss a meal?
- 🍏 Do you get dizzy when standing up?
- 🍏 Do you get dizzy when looking up?
- 🍏 Do you get dizzy when bending over?
- 🍏 Do you get dizzy with quick head movements?
- 🍏 Do you get dizzy turning over in bed? Right? Left?
- 🍏 Do you tend to get stressed easily?
- 🍏 Have you ever had a neck or back injury?
- 🍏 Do you get dizzy walking down the aisle in the grocery store?
- 🍏 Do loud sounds make you dizzy?
- 🍏 Does pressure in your ear make you dizzy?
- 🍏 Does dizziness occur just prior to your menses cycle?

Have you ever experienced any of the following symptoms? Please check all that apply.

- 🍏 Double vision
- 🍏 Numbness of the face or arms/legs
- 🍏 Blurred vision or blindness
- 🍏 Weakness in the arms/legs
- 🍏 Confusion or loss of consciousness
- 🍏 Difficulty with speech
- 🍏 Difficulty with swallowing
- 🍏 Tingling around the mouth

Please list all medications (prescription and over the counter) and supplements you take on a regular basis on the patient medication form.

Please describe your dizziness in your own words and note any additional information that may be helpful in treating your dizziness.

