Physician's Hearing Service

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VNG INSTRUCTIONS

You have been scheduled for a videonystagmography (VNG). The VNG is a test designed to give your physician information about the source of your dizziness or unsteadiness. The test takes about 90 minutes to complete. During the test you will be wearing specialized goggles which record all eye movements you may have in correlation to any dizziness symptoms you may be experiencing at the time of your testing. There is minimal body repositioning, however none are strenuous or cause pain. Although many people experience dizziness during the test, it is of short duration and by the completion of the test all signs of dizziness should subside. Please note, dizziness symptoms vary from patient to patient which makes it difficult to predict how you, specifically, may react.

IN ORDER TO ACHIEVE AN ACCURATE TEST RESULT, THE FOLLOWING INSTRUCTIONS NEED TO BE CAREFULLY FOLLOWED:

1. Please refrain from eating or drinking at least two hours before the scheduled testing. **PLEASE AVOID CAFFEINE** (coffee, soda, chocolate)
2. Discontinue any narcotic pain relief medication/sedatives for **TWO DAYS** prior to the test.
3. **No alcoholic beverages or liquid medications** containing alcohol for **TWO DAYS** prior to the test.
4. For **ONE WEEK** prior to the test, discontinue all medications for dizziness (i.e. **Meclizine**) or any other medications that should not be taken as instructed by Dr. Wikholm/Dr. VandeGriend
5. Face should be washed thoroughly. **PLEASE DO NOT USE EYE MAKEUP**.
6. Dress comfortably and casually. This exam does require a certain amount of easy activity.
7. **Please have someone drive you to your appointment, as you will likely be dizzy or may have symptoms stronger after the test.**
8. We have an automated system in place to call and confirm all appointments, however it is the patient's responsibility to remember his/her own appointment. Please give 48 hour notice of any cancellation or to reschedule an appointment. Additionally, missing an appointment means that someone else who may need the test is waiting unnecessarily.

   We reserve the right to charge $100 for any missed appointment, which is not covered by insurance.

Medications may be resumed immediately following the VNG examination. Your cooperation in following these instructions will improve the quality of your examination. Once the examination is completed, it takes time to analyze the data to obtain accurate results. You will be asked to make a follow up appointment with your physician to go over the test results and recommendations.

Failure to follow these instructions may limit the effectiveness of the examination. As a result, if in our judgment the procedures were not followed adequately, the examination will be rescheduled.

_____ has a VNG appointment

scheduled for _____ at _____.

*****PLEASE COMPLETE ATTACHED QUESTIONNAIRE PRIOR TO YOUR APPOINTMENT. INCOMPLETE PAPERWORK WILL RESULT IN RESCHEDULING OF VNG TEST.**

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Patient`s Name: _____ Date:_____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? PLEASE CIRCLE **YES** OR **NO** AND CIRCLE THE EAR INVOLVED IF APPROPRIATE.

YES	NO	Dizziness? Describe the dizziness in detail. What do you experience?	
YES	NO	Difficulty hearing? Both ears?	Right Left
YES	NO	Does your hearing change with dizziness?	Right Left
YES	NO	Do you have noise in your ears? Describe the noise:	Right Left
YES	NO	Does the noise in your ears change when you are dizzy?	
YES	NO	Do you have fullness or stuffiness in your ears?	Right Left
YES	NO	Do you have pain in your ears?	Right Left
YES	NO	Do you have discharge from your ears?	Right Left

IF YOU HAVE DIZZINESS, PLEASE ANSWER THE FOLLOWING. PLEASE CIRCLE **YES** OR **NO**, and FILL IN THE BLANK SPACES WITH SPECIFIC DETAILS.

		When did your dizziness first occur?
		How often do you become dizzy?
		If you have attacks of dizziness, how long does it last?
YES	NO	Is there any warning that an attack of dizziness is about to start? If yes explain:
YES	NO	Do your dizziness attacks at any particular time of day or night? If yes, when?
YES	NO	Are you completely free of dizziness between attacks?
YES	NO	Does change of position make you dizzy? Which movements?
YES	NO	Do you become dizzy when you cough? Sneeze? Have a bowel movement?
YES	NO	Do you become dizzy when rolling over in bed? To the right? To the left?
YES	NO	Do you have any possible cause for your dizziness? What?

DO YOU KNOW ANYTHING THAT WILL:

YES	NO	Stop your dizziness or make it better? If yes, what?
YES	NO	Makes your dizziness worse? If yes, what?

CAN ANY OF THE FOLLOWING MAKE YOUR DIZZINESS WORSE OF TRIGGER/PROVOKE AN ATTACK?

YES	NO	Fatigue?
YES	NO	Exertion?
YES	NO	Hunger?
YES	NO	Menstrual period?
YES	NO	Stress?
YES	NO	Emotional upset?
YES	NO	Alcohol?

PLEASE ANSWER

YES	NO	Did you ever injure your head? If so, when?
YES	NO	Did you suffer from motion sickness before age 12? What type?
YES	NO	Have you taken medications in the past for dizziness? If so, what kind? Did the medications help?
YES	NO	Does caffeine affect your dizziness? How?
YES	NO	Does alcohol affect your dizziness? How?

IS YOUR DIZZINESS ASSOCIATED WITH ANY OF THE FOLLOWING SENSATIONS? **PLEASE READ THE ENTIRE LIST FIRST**. THEN CIRCLE **YES** OR **NO** TO DESCRIVE YOUR FEELINGS MOST ACCURATELY.

YES	NO	Lightheadedness or swimming sensation in head?
YES	NO	Blacking out or loss of consciousness?
YES	NO	Tendency to fall?
YES	NO	Objects spinning or turning around you?
YES	NO	Sensation that your are turning or spinning inside, without outside objects remaining stationary?
YES	NO	Loss of balance when walking in the light? If yes: do you tend to veer to the right or left?
YES	NO	Loss of balance when walking in the dark? If yes: do you tend to veer to the right or left?
YES	NO	Headache?
YES	NO	Nausea or vomiting?
YES	NO	Pressure in the head?
YES	NO	Tingling in the fingers or toes?
YES	NO	Tingling around the mouth?

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? PLEASE CIRCLE YES OR **NO** AND CIRCLE **CONSTANT** OR IN **EPISODES**.

YES	NO	Double vision?	CONSTANT	IN EPISODES	
YES	NO	Blurred vision?	CONSTANT	IN EPISODES	
YES	NO	Blindness?	CONSTANT	IN EPISODES	
YES	NO	Numbness of the face or extremities?	CONSTANT	IN EPISODES	
YES	NO	Weakness of the arms or legs?	CONSTANT	IN EPISODES	
YES	NO	Clumsiness of the arms or legs?	CONSTANT	IN EPISODES	
YES	NO	Confusion?	CONSTANT	IN EPISODES	
YES	NO	Loss of consciousness?	CONSTANT	IN EPISODES	
YES	NO	Difficulty with speech?	CONSTANT	IN EPISODES	
YES	NO	Difficulty with swallowing?	CONSTANT	IN EPISODES	
YES	NO	Neck pain?	CONSTANT	IN EPISODES	