

VNG Patient Packet

Appointment Date: _____ Appointment Time: _____

Videonystagmography (VNG)

Videonystagmography (VNG) is used to evaluate patients with dizziness, vertigo, or balance dysfunction. The balance center of your inner ear (the vestibular system) and eyes movements are connected through the vestibulo-ocular reflex. With this reflex, the vestibular system monitors the position and movements of the head in order to maintain stable vision. During the VNG test, eye movements are recorded, and give information about the central and peripheral balance system. VNG testing consists of three parts: oculomotor evaluation, positioning/positional testing, and caloric stimulation of the vestibular system.

The test takes approximately 1.5 hour (90 minutes) to complete. Some dizziness is normal with VNG testing, and typically is of short duration. It is advised to bring someone to the appointment to drive you home, should you feel unwell afterwards.

You must discontinue use of the following medications for 48 hours prior to your test:

- Allergy pills
- Tranquilizers (Valium, Librium, Xanax, etc.)
- Sedative pills (all sleeping pills or tranquilizers)
- Decongestants/Antihistamines (Benadryl, Sudafed, Dimetapp, Chlor Trimeton, Seldane)
- Pain pills
- Diet pills
- Nerve/muscle relaxant pills (Robaxin, Valium)
- Dizziness pills (Antivert, Meclizine, Bonine, ear patches, etc.)
- Aspirin or aspirin substitutes (Tylenol, etc.)
- Narcotics/Barbiturates (Codeine, Demerol, Percodan, Phenobarbital, antidepressants)

Additional instructions:

- Wear comfortable clothing and flat, supportive shoes.
- Clean face, no facial or eye makeup.
- If you are a contact wearer, be prepared to remove them if it interferes with the testing.
- No solid foods for 2 to 4 hours before the test.
- No coffee, tea, or cola after midnight on the day of the test.
- No alcoholic beverages/liquid medication containing alcohol 48 hours before the test.
- Discontinue all medication for 48 hours prior to the test, except "maintenance" medications for your heart, blood pressure, diabetes, or seizures, and any medications deemed by your physician to be necessary.

Please consult your physician with any questions. It is helpful if you bring a list of the medications you take regularly, or even the medications themselves. Medications can be resumed immediately following the VNG testing procedures. If there are any questions about the test or medication, please contact your doctor or our office at 703-499-8787.



Patient Questionnaire Please complete before your appointment and bring it with you.

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

Check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Spinning (Vertigo) | <input type="checkbox"/> Pressure in the Head |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Sensitivity to Light / Noise |
| <input type="checkbox"/> Swimming Sensation in the Head | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Blackout / Loss of Consciousness | <input type="checkbox"/> Numbness of Face or Arms / Legs |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Blurred Vision or Blindness |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Weakness in Arms / Legs |
| <input type="checkbox"/> Tinnitus (Noise in Head/Ears) | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Full Feeling in the Ear(s) | <input type="checkbox"/> Difficulty with Speech |
| <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Difficulty with Swallowing |
| <input type="checkbox"/> Tendency to Fall to the (circle one): | <input type="checkbox"/> Tingling Around the Mouth |
| Right Left Forwards Backwards All Directions | |

Describe your "dizziness" attack(s):

Is your dizziness constant or periodic? _____

When did first attack occur? _____

How long since 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? _____

Have you changed medications prior to the onset of your dizziness? _____

Have you recently gotten new glasses / contacts? _____

Have you seen any specialists regarding your dizziness? _____

What brings on your dizziness? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Exertion or Overwork | <input type="checkbox"/> Quick Head Movements |
| <input type="checkbox"/> Heavy Lifting or Straining | <input type="checkbox"/> Turning Over in Bed (Right or Left) |
| <input type="checkbox"/> Missing a Meal | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Going from Sitting/Lying Down to Standing | <input type="checkbox"/> Loud Sounds |
| <input type="checkbox"/> Looking Up | <input type="checkbox"/> Walking Down the Aisle in the Grocery Store |
| <input type="checkbox"/> Bending Over | <input type="checkbox"/> Menstrual Cycle |

Health Questions. Check all that apply.

Do you or have you ever...

- | | |
|---|---|
| <input type="checkbox"/> Had Ear Surgery | <input type="checkbox"/> Had an Autoimmune Issue Such as Rheumatoid Arthritis |
| <input type="checkbox"/> Had Difficulty with Hearing | <input type="checkbox"/> Had an Acute Ear/Sinus Infection |
| <input type="checkbox"/> Had Fluctuating Hearing Loss | <input type="checkbox"/> Have Diabetes |
| <input type="checkbox"/> Had Pain/Discharge in Ears | <input type="checkbox"/> Have High or Low Blood Pressure |
| <input type="checkbox"/> Been Exposed to or Work in Loud Noise | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Use Tobacco | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Use Alcohol | <input type="checkbox"/> Back/Neck/Knee Pain |
| <input type="checkbox"/> Had Cold Sores/Shingles/Herpes Simplex Virus | <input type="checkbox"/> Orthopedic Surgery |

Please list any medications/supplements you take regularly:

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



Cancellation

Please give us at least 72 hours notice if you need to cancel or reschedule this test for any reason and plan to arrive 15 minutes before your appointment time.

Late arrival or failure to give 72 hours notice results in a \$150.00 fee!

Medical Records

In order to provide you with the best care, we ask that if you have any medical records regarding your dizziness or balance problem, please have your primary care doctor or specialist send them to our clinic prior to your initial appointment. This is not required to undergo testing but aids our audiologist in evaluating your condition. This includes past ENG's, VNG's, EMG's, MRI's, CT scans, hearing tests or any other related studies. If you don't know how to obtain or send your medical records, call our office before your appointment and we will be glad to help locate them for you.

Insurance

Videonystagmography (VNG) is covered by most medical insurances. Please check your policy for coverage details including deductibles and copayments. Insurance co-payments are due at the time of visit.

Patient Name (Sign)

Date

Patient Name (Print)



I, _____ authorize Potomac ENT/CADENT to perform the following procedure:

Auditory Brainstem Response - ABR

Videonystagmography- VNG

Electrocochleography- ECOG

Otoacoustic Emissions- OAE

I _____ also understand that if I do not cancel my appointment in 72 hours, **I will be responsible for \$150.00 cancellation fee.**

Patient/Responsible Signature _____ Date: _____

Witness: I have explained these instructions, alternatives, and expectations to the patient, and believe he/she has been adequately informed and has consented.

Witness Signature _____ Date: _____