Metropolitan ENT
& Facial Plastic Surgery

VIDEONYSTAGMOGRAPHY INSTRUCTIONS

You have been scheduled for a balance test. The VNG examination is a simple, painless procedure requiring about one hour. The test will involve looking at various visual stimuli, moving the head and body into different positions, as well as stimulating the ears with cool and warm air. If you have any problems with your neck or back, please inform us *prior* to the beginning of the evaluation.

This test will likely cause some dizziness, however, this generally passes within a few minutes. In rare instances, the dizziness lasts a little longer, making it inadvisable to operate a motor vehicle for a short time. You should make arrangements for someone to be available to drive you home in the event that you are unable to do so.

Please dress comfortably. Women may wish to wear slacks. If you wear contact lenses, please bring your glasses with you in case you need to remove your lenses and you may also wish to bring your eyeglass case. If you have interocular lenses, please inform the audiologist on the day of the test.

IMPORTANT:

- **No eating, drinking, or smoking for 3 hours prior to the time of your appointment.**
- **Do not use any eye makeup, including eyeliner or mascara.**
- **Certain medications and ALL alcoholic beverages affect the results of this test. It is imperative that you DO NOT take any of the following medications or beverages for a minimum of 48 hours (two days) prior to your appointment.**

Sleeping Pills	Diuretics
Tranquilizers	Sedatives
Antihistamines	Muscle Relaxants
Anti-dizzy medications	Barbiturates
Anti-depressants	Anti-anxiety medications
Pain medication	
Alcoholic Beverages (including beer and wine)	

Please do not discontinue prescription medications without checking with the physician who prescribed them.

If you have any questions, or cannot go without a medication listed above, please call our Audiologist prior to the day of the evaluation at 703-313-7700.

www.MetropolitanENT.com

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PATIENT QUESTIONAIRE FOR VIDEONYSTAGMOGRAPHY

Patient Name:_____ Date of Birth:_____
Print Name Last First MI

Address:_____

City/State/Zip:_____

Home Phone:(_____)_____Work Phone:(_____)_____

Occupation:_____

Referring Physician and/or Family Physician:_____

INITIAL PROBLEM & DESCRIPTION:

Problem(s) you are seeking help with:_____

When did the problem begin?_____

What were the initial symptoms and circumstances?_____
_____

What have you been told your problems is due to?_____

What do YOU think the problem is due to?_____

Do you feel any of the following? Have these feelings changed since the problem began?

	Yes	**No**	**Feeling Is Gone**	**Somewhat Improved**	**Somewhat Worse**	**No Change**
Spinning	___	___	___	___	___	___
Tumbling	___	___	___	___	___	___
Rocking	___	___	___	___	___	___
Tilted	___	___	___	___	___	___
Giddy	___	___	___	___	___	___
Lightheaded	___	___	___	___	___	___
Disoriented	___	___	___	___	___	___
Other _____	___	___	___	___	___	___

PATIENT QUESTIONAIRE
Page 2

INITIAL PROBLEM & DESCRIPTION (continued)

How often do spells occur?
___constantly
___daily
___weekly (___ times/week)
___monthly (___ times/month)
___yearly (___ times/year)
___never

When are the symptoms mostly present?
___walking
___standing
___sitting
___lying down
___anytime

Please check the following:

	Yes	**No**	**During a Spell**
Do you have difficulty with balance?	___	___	___
Have you fallen?	___	___	___
Do you have a sensation of spinning or tumbling?	___	___	___
Do you have a sensation of rocking or swaying?	___	___	___
Do you ever feel pulled to the ground?	___	___	___
Do you have nausea or vomiting?	___	___	___
Do you feel lightheaded, about to faint, or black out?	___	___	___
Have you lost consciousness (Fainted or blacked out)?	___	___	___
Do you have double vision (side-by-side or above-and-below)?	___	___	___
Did you need to wear an eye patch as a child?	___	___	___
Do you have visual symptoms (jagged lines or loss of vision)?	___	___	___
Does your vision jump while walking or riding?	___	___	___

Is the dizziness or vertigo brought on or worsened by:

	Yes	**No**
Lying down or rolling over in bed?	___	___
Reaching or bending?	___	___
Loud noises?	___	___
Hot baths or showers?	___	___
Coughing, sneezing, straining, or blowing your nose?	___	___
Exercise?	___	___
Sitting up or standing up?	___	___
Menstrual cycle?	___	___
Reading?	___	___
Turning your head while walking?	___	___
Supermarket aisles, malls, tunnels, bridges, or heights?	___	___
Automobile rides?	___	___
Windshield wipers?	___	___
Restaurants or movie theaters?	___	___
Walking in the dark or on uneven surfaces?	___	___

PATIENT QUESTIONAIRE
Page 3

HEADACHES?

Is the pain worse usually on one or both sides of your head? ___one side ___both sides
Is it always in the right or left side? ___right ___left
Are the headaches accompanied by nausea or vomiting? ___yes ___no
Do any foods or drinks cause a headache? ___yes ___no
If yes, please list:_____
Does sleep often relieve the headache? ___yes ___no
How often do you take medication for the headache?_____
How long do the headaches last?_____
For females, do the headaches coincide with your menstrual flow? ___yes ___no

HEARING & TINNITUS PROBLEMS?

Do you have hearing loss? ___right ___left ___both
Does your hearing fluctuate? ___yes ___no
Do you hear tinnitus (ringing) in your ears? ___right ___left ___both
Is the tinnitus high pitched or low pitched? ___high ___low
Is the tinnitus constant, brief, or cricket-like?_____
Do you experience the following?:
Right ear: ___pain ___pressure ___fullness ___popping ___clicking
Left ear: ___pain ___pressure ___fullness ___popping ___clicking
Have you had:
___frequent ear infections ___injuries to the ear ___discharge or draining
___ear surgeries ___perforated or torn eardrum

FAMILY HISTORY

Are you single or married? ___single ___married
Do you live alone? ___yes ___no
Number of children?_____ General health?_____
Number of siblings?_____ General health?_____

Do you have a family history of:

	Yes	No
Hearing loss?	___	___
Frequent headaches?	___	___
Heart disease or hypertension?	___	___
Any bleeding disorders?	___	___
Ataxia or balance disorders?	___	___
Diabetes?	___	___
Stroke or aneurysm?	___	___
Meniere's disease?	___	___