KEY HEARING

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Instructions and What to Expect From Your VNG

*****PLEASE READ CAREFULLY 48 HOURS BEFORE TESTING*****

Your Time at the Appointment
Videonystagmography (VNG) is a series of tests designed to evaluate the balance system commonly referred to as the "inner ear." During the VNG, goggles housing sophisticated cameras will be placed over your eyes and will monitor your eye movements to record nystagmus. Nystagmus is a rapid, involuntary eye movement generated by the balance system. For most tests you will be seated, observing lights. The last portion of testing is called caloric testing. For this portion, you will be lying down and cool/warm air will be introduced to the ear. Throughout the testing, we will make every attempt to make your visit comfortable as well as educational. The exam takes approximately one hour. You may experience brief episodes of dizziness during some portions of the test.

Once your evaluation is completed each part is carefully evaluated and reviewed. Once the interpretation has been made a detailed report will be forwarded to your referring physician. You will be contacted to schedule a follow up appointment with them to review the results and discuss treatment options.

Transportation
Because the sensation of motion will sometimes linger after testing, if possible we encourage you to have someone accompany you to and from the appointment. If this is not possible try and plan your day to include at least an extra 15 to 30 minutes after your appointment before leaving the office.

Insurance and Paperwork
Please remember to bring your insurance information as we are a separate office and will need this for our records. You will be asked to fill out medical information, as we are required to have this for our records. If you do not have the paperwork completed, please plan to arrive at your appointment 30 minutes before the scheduled time to complete this information.

Meals
Please eat lightly for 12 hours prior to your appointment. If your appointment is in the morning you may have a light breakfast such as toast, avoid acidic drinks such as orange juice. If your appointment is in the afternoon you may have a light breakfast and a light snack for lunch. ***Please avoid caffeine beverages such as coffee or soft drinks***.

MRI
If you schedule an MRI before your appointment, you must schedule it three hours prior. If you know you will need sedatives for you MRI, it will need to be done on a different day. Sedatives can influence the body's response to the test, thus giving a false or misleading result.

Make-Up
Due to the sensitive nature of the infra red goggles, **please do not wear any eye or facial make-up to your appointment**. This includes eyeliner, eye shadow, mascara, false eye lashes, etc.

Medication etc.
Certain substances can influence the body's response to the test, thus giving a false or misleading result. **Therefore you must refrain from certain medications and alcohol for 48 hours before testing**. There is a partial list of medications on the following page which need to be held for 48 hours before testing. **DO NOT refrain from life sustaining medications.** If you have any questions about medications that you are currently taking, please call our office for clarification.

Failure to comply with these instructions will compromise test results and may result in your test being rescheduled for another day. Please notify the office within 24 hours if you cannot keep this appointment.

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MEDICATIONS TO BE STOPPED 48 HOURS BEFORE YOUR VNG

This list is NOT all inclusive

If you have any questions regarding your medications, please call our office for verification at least **2 full days** before testing.

Over-the-counter medications:
all allergy medications
all cold medications
all sleep aids
anti-itch creams containing antihistamines
cough syrups

Allergy Meds
Allegra AlleRx
Antihistamine sprays
Astelin nasal spray
Astepro nasal spray
Benadryl
Chlor-trimeton
Claritin
Clarinex
Disophrol
Nolamine
Pataday eye drops
Patanase nasal spray
Zyrtec

Herbal remedies
Ginkgo
Valerian
Etc.

Pain Meds
Codeine
Darvocet
Demerol
Dilaudid
Lortab
Morphine
Oxycontin
Oxycodone
Paxicodone
Percocet
Phenaphen
Phrenilin
Topamax
Vicodin
Wygesic
Zydone

Dizziness/Nausua/Dirrheal
Antivert
Atarax
Bucladin
Compazine
Dramamine
Meclizine
Phenergan
Ru-vert
Scopolamine patch
Thorazine
Transdermail
Zofran

Psychotherapeutic Agents/Antidepressants
BuSpar
Celexa
Clorazil
Concerta
Depakote
Elavil
Haldol
Klonopin
Librium
Lithium
Miltown
Paxil
Prozac
Ritalin
Sinequan
Sleeping Pills
Stelazine
Strettera
Trazadone
Triavil
Valium
Vivactil
Wellbutrin
Xanax
Zoloft
Zyprexa

Restless Leg
Zyprexa Requip
Mirapex

Other
Neurontin

Seizure Meds
Dilantin
Mabaral
Tegretol
Phenobarbital
check with you doctor before stopping these medications

These Medications are okay: Heart medication, cholesterol medication, glaucoma medication, blood pressure medication, thyroid medication, diabetes medication, reflux medication, hormone treatment, birth control pills, asthma inhalers, regular/plain Tylenol, Imodium and Pepto Bismol. Always consult with your physician before discontinuing any prescribed medication.

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PATIENT QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. For the purpose of this questionnaire, the word 'dizziness' refers to any of these symptoms. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	Do you experience motion sickness, airsickness or seasickness?
☐	☐	Did you have motion sickness as a child?
☐	☐	Do you have a family history of motion sickness? parent?___ sibling?____ child?____
☐	☐	Do you have migraine headaches?
☐	☐	Were you exposed to any solvents, chemicals, etc.?
☐	☐	Did you have any injuries to your head? When? _____
☐	☐	If you received a head injury, were you unconscious?
☐	☐	Have you ever had a neck injury?
☐	☐	Have you ever fallen? How many times? _____ Where? _____ Inside the home? _____ Outside the home? _____
☐	☐	Are you afraid of falling?
☐	☐	Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid) What? _____
☐	☐	Do you use alcohol?
☐	☐	Do you smoke? How much? _____

II. The following section refers to your dizziness/vertigo/imbalance/unsteadiness. Please fill out to the best of your ability.

YES	NO	
☐	☐	My dizziness is constant? If you answered yes, please go to section III.
☐	☐	If in attacks, how often? _____
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Is the dizziness provoked by head/body movement? If so, which direction?_____
☐	☐	Is the dizziness better or worse at any particular time of the day? If so, when? _____
☐	☐	Do you know of anything that will stop your dizziness or make it better? What? _____
☐	☐	…… make your dizziness worse? What? _____
☐	☐	…… precipitate an attack? What? _____
☐	☐	Do you know any possible cause of your dizziness? What? _____

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III. Do you experience any of the following sensations? Please read the entire list first then check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
☐	☐	Light headedness?
☐	☐	Swimming sensation in the head?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall……. to the right or left.
☐	☐	……. forward or backward
☐	☐	Loss of balance when walking….. veering to the right?
☐	☐	…… veering to the left?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?

Iv. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	Double vision?	Constant	In Episodes
☐	☐	Blurred vision or blindness?	Constant	In Episodes
☐	☐	Spots before your eyes?	Constant	In Episodes
☐	☐	Numbness of face, arms or legs?	Constant	In Episodes
☐	☐	Weakness in arms or legs?	Constant	In Episodes
☐	☐	Confusion or loss of consciousness?	Constant	In Episodes
☐	☐	Difficulty in swallowing?	Constant	In Episodes
☐	☐	Tingling around the mouth?	Constant	In Episodes
☐	☐	Difficulty speaking?	Constant	In Episodes

V. Do you have any of the following symptoms? Please check the box for either YES or NO and circle the ear involved.

YES	NO				
☐	☐	Difficulty in hearing?	Both Ears	Right Ear	Left Ear
		When did this start? _____	Is it getting worse? _____		
		Does the hearing change with your symptoms? If so, how? _____			
☐	☐	Noise in your ears?	Both Ears	Right Ear	Left Ear
		Describe the noise? _____			
		Does the noise change with your symptoms? If so, how? _____			
☐	☐	Does anything stop the noise or make it better? _____			
☐	☐	Fullness or stuffiness in your ears?	Both Ears	Right Ear	Left Ear
		Does this change when you are dizzy? _____			
☐	☐	Pain in your ears?	Both Ears	Right Ear	Left Ear
☐	☐	Discharge from your ears?	Both Ears	Right Ear	Left

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Dizziness Handicap Inventory

Scoring: A yes response on the inventory receives 4 points.
A sometimes response on the inventory receives 2 points.
A no response on the inventory receives 0 points.
The points may then be combined totally to assign a total score or they may be combined by subscale.

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes," or "no," or "sometimes" to each question as it pertains to your dizziness or unsteadiness problem only.

1. Does looking up increase your problem?_____
2. Because of your problem, do you feel frustrated? _____
3. Because of your problem, do you restrict your travel for business or recreation? _____
4. Does walking down the aisle of a supermarket increase your problem? _____
5. Because of your problem, do you have difficulty getting into or out of bed? _____
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties? _____
7. Because of your problem, do you have difficulty reading? _____
8. Does performing more ambitious activities like sports, dancing, household chores (such as sweeping or putting dishes away) increase you problem? _____
9. Because of your problem, are you afraid to leave your home without having someone accompany you? _____
10. Because of your problem, have you been embarrassed in front of others? _____
11. Do quick movements of your head increase your problem? _____
12. Because of your problem, do you avoid heights? _____
13. Does turning over in bed increase your problem? _____
14. Because of your problem, is it difficult for you to do strenuous housework or yard work? _____
15. Because of your problem, are you afraid people may think you are intoxicated? _____
15. Because of your problem, is it difficult for you to go for a walk by yourself? _____
16. Does walking down a sidewalk increase your problem? _____
17. Because of your problem, is it difficult for you to concentrate? _____
18. Because of your problem, is it difficult for you to walk around your house in the dark? _____
19. Because of your problem, are you afraid to stay home alone? _____
20. Because of your problem, do you feel handicapped? _____
21. Has your problem placed stress on your relationships with members of your family or friends? _____
22. Because of your problem, are you depressed? _____
23. Does your problem interfere with your job or household responsibilities? _____
24. Does bending over increase your problem? _____