VNG PRE-TEST INSTRUCTIONS

Following these instructions is important for accurate test results. Please contact our office if you have any concerns regarding your ability to follow these instructions.

Test Description: Videonystagmography (VNG) testing is performed in our office by an audiologist and takes approximately 90 minutes, including a hearing test. You will follow-up with your physician after the test to review the results. Throughout the test you will be wearing goggles that will record your eye movements. Portions of the test may induce a sensation of motion, which is brief and temporary. Since each patient is unique and may experience side effects, *we strongly recommend having a companion accompany you to this test*.

The VNG test battery has three parts: (1) following moving visual targets on a screen in front of you, (2) sitting/laying in different positions, and (3) stimulating each ear with air (warm and cool).

Pre-Test Instructions:

1. DISCONTINUE certain medications/substances for 72 hours prior to your test. Certain medications (listed below) can influence the body's response to the test. If you have any questions, please consult your physician. • Alcohol including beer, wine, liquor, cough medications • Analgesics/Narcotics such as codeine, Tylenol with codeine, Demerol, Phenaphen, Percocet, Darvocet • Antihistamines/Decongestants such as Claritin, Benadryl, Chlortrimeton, Dimetapp, Disophrol, Actifed, Teldrin, Triaminic, and any other over-the-counter cold remedies • Medication for dizziness and/or vertigo such as Antivert, Meclizine, Ru-Vert • Medication for nausea such as Compazine, Dramamine, Atarax, Bucladin, Phenergan, Thorazine, Scopolamine Transdermal • Sedatives such as Ambien, Tylenol PM, Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill • Tranquilizers such as Xanax, Valium/Diazepam, Klonopin, Zoloft, Ativan, Librium, Atarax, Vistaril, Serax, Librax, Tranxene, Prozac

2. CONTINUE medications including blood pressure medications, heart medications, thyroid medications, insulin, estrogen, etc.

3. NO Caffeine for 48 hours prior to your test, including beverages and medications (diet pills).

4. NO Tobacco on the date of the test.

5. DO NOT EAT for 4 hours prior to your test. If you are a diabetic, please eat as necessary to maintain proper blood sugar levels. If your test is in the afternoon, eat a light breakfast such as toast and juice.

6. DO NOT WEAR ANY FACIAL MAKEUP including foundation, eye makeup (eye liner, mascara, eye shadow), and/ or facial creams; these WILL interfere with the testing and you will be required to remove the makeup prior to testing.

7. DO NOT WEAR CONTACT LENSES. Please wear/ bring glasses.

8. WEAR COMFORTABLE CLOTHING. Preferably no skirts/ dresses, as you will be lying down for a portion of testing.

Your insurance coverage for this test may vary depending on your insurance benefits. Please be aware of your financial responsibility agreement made between you and your insurance company prior to this appointment.

To avoid the possibility of your appointment being rescheduled please remember to bring the following:

- Your insurance card(s)
- Referral Form/Authorization (if required)
- Form of ID
- Prescription from physician
- List of current medications
- Completed Dizziness History Questionnaire (attached)

Address:
Garden State Hearing and Balance Center
250 Route 37 West
Toms River, New Jersey 08755

Appointment Date & Time: ____

Please arrive 15min prior to your appointment and contact our office with any questions **732-818-3610**.

Date: ________________

DIZZINESS HISTORY QUESTIONNAIRE

Name: ____ **Date of Birth:** _________________

1. Have you ever been evaluated for dizziness? YES NO
    a. If so, when?
    b. What were the results?

2. When was your initial episode of dizziness?

3. When was your most recent episode of dizziness?
    a. What were the circumstances?

4. Currently, your dizziness…..
    a. Is constant
    b. Is always there, but changes in intensity
    c. Comes and goes

    If it comes and goes…

    How long does it typically last? (circle one)

    Seconds Minutes Hours

    How often does it typically occur?

    ______ (times per) hour day week month year (circle one)

5. Your dizziness mostly consists of (circle all that apply)….
    a. Spells of spinning with nausea
    b. Off balance sensation without dizziness
    c. A light-headed or near faint sensation
    d. Other. Please explain…

6. Between episodes, you feel…
    a. Dizzy or off-balance all the time
    b. Normal
    c. Other. Please explain….

7. Your episodes occur (circle all that apply)….
    a. Spontaneously. Nothing you do seems to bring them on…
    b. Only when standing or walking.
    c. In relation to any head/body motion.
    d. In relation to only certain head/body positions. Please describe….

8. When you roll over in bed, (circle one)….
    a. Nothing unusual happens
    b. The room seems to spin sometimes
    c. The room spins every time

9. Is there anything you can do to make your dizziness go away? (Sit, lay down, close eyes, etc.) Please explain:

10. Circle all that apply:
    a. You have hearing difficulty…… Left Right Both
    b. You have ringing or other sounds in the ear…. Left Right Both
    c. You have fullness in the ear….. Left Right Both
    d. You have had ear surgery….. Left Right Both

11. Circle yes or no:

Did you have cold, flu, or virus symptoms shortly before the onset of your dizziness?	YES	NO
Did you cough, lift, sneeze, fly on a plane, swim under water, or have a head trauma shortly before the onset of your dizziness?	YES	NO
If you had a head trauma, did you lose consciousness completely?	YES	NO
Were you exposed to any irritating fumes, paints, etc. at the time of your dizziness?	YES	NO
Do you get dizzy when you haven't eaten for long periods of time?	YES	NO
Is your dizziness connected with your menstrual period?	YES	NO
Do you consider yourself to be an anxious or tense type of person?	YES	NO
Are you under a great deal of stress?	YES	NO

12. In the past year, have you had…? (circle all that apply)
    a. Loss of consciousness
    b. Seizures or convulsions
    c. Slurring of speech
    d. Difficulty swallowing
    e. Spots before the eyes
    e. Occasional loss of vision
    f. Severe headache/ migraine
    g. Weakness in one hand, arm, or leg
    h. Tingling around mouth
    i. Loss of balance when walking
    k. Tendency to fall
    l. Heart palpitations

13. You have or have had… (circle all that apply)
    a. Diabetes
    b. High blood pressure
    c. Arthritis
    e. Stroke
    f. Migraine headaches
    g. Neck and/or back injury
    g. Irregular heartbeat
    h. Allergies

14. Please check below any medications you have taken or are currently taking for dizziness:

	Taken in Past	Currently Taking	Helps?
Antivert (Meclizine)	______	______	______
Valium (Diazepam)	______	______	______
Dyazide (water pill)	______	______	______