



**PATIENT NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**TEST DATE & TIME:** \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_:\_\_\_\_

**REFERRED BY:** *Dr. Mahesh Parameswaran*

The provider has recommended you complete a **Videonystagmography (VNG) examination**. This is a test of your balance mechanism. The evaluation will take approximately 90 minutes. The test is not physically demanding but you will feel tired afterwards. For the duration of the test you will wear goggles with tiny cameras embedded in them which look for specific eye movements associated with dizziness. The examination consists of 3 different portions. The first portion evaluates your ability to follow a “visual target” with your eyes only (*i.e. not moving your head*). The second portion focuses on your eye movements in response to changes in head and body positions. And in the third portion, your ears will be irrigated with cool and warm air/water, producing a sense of motion (*it is normal to feel dizzy during this portion of the test*). The data collected during these tests will help determine the integrity of the inner ear balance system.

**Please follow these guidelines in preparation for your evaluation:**

1. Do not wear any eye makeup. (*Mascara and eyeliner can interfere with the goggles ability to track your eye movements*)
2. Do not wear contact lenses.
3. You may wish to wear comfortable clothing.
4. Eat lightly before and after the test. The test may make you dizzy and cause nausea.
5. You may wish to have someone bring you to the test and take you home; since there is a chance you will feel dizzy afterwards
6. Refrain from taking these forms of medications for at least 48 hours prior to your test time:
  - a. Tranquilizers/sleeping pills
  - b. Anti-dizziness medications
  - c. Antihistamines
  - d. Barbiturates
  - e. Sedatives/muscle relaxants**\*Do not discontinue use of any prescribed medication without consulting your physician first.**
7. Refrain from alcohol and cigarettes for 48 hours prior to your evaluation.

**Due to the amount of time this procedure takes to complete and since it takes a large part of the audiologist’s schedule, it is important to notify us as soon as possible if you are unable to keep your appointment. We require at least a 48 hour notice of cancellation; to avoid cancellation fees, we ask that you give us as much notice as possible. Please note that you will only be allowed to reschedule the testing once.**

- If you fail to cancel/reschedule your appointment without notifying us 48 hours prior to your appointment, we reserve the right to charge a \$50.00 fee that is not covered by your insurance company.*
- If you fail to cancel/reschedule your appointment any less than 48 hours prior to your appointment, we reserve the right to charge a \$75.00 cancellation fee that is not covered by your insurance company.*
- If you fail to show or call the day of your appointment, we reserve the right to charge a \$100.00 no show fee that is not covered by your insurance company.*

**Thank you for your cooperation and understanding.**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**PATIENT NAME:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
**TEST DATE & TIME:** \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_:\_\_\_\_  
**AUDIOLOGIST:** *Dr. Kimberly Johnson*

**Please answer these questions to the best of your ability.**

**History:**

Briefly describe your problem:

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**Describe your first episode:**

Date of onset: \_\_\_\_\_

What were you doing when it began?

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What were the first symptoms?

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How long did these symptoms last?  Seconds  Minutes  Hours  Days  Constant

On a scale of 1 to 10, how severe were they? \_\_\_\_\_  
(1 being Not Severe and 10 being Extremely Severe)

Do you know what caused your problem?  Yes  No  
If yes, what? \_\_\_\_\_

Have you had more than one episode of dizziness?  Yes  No  
If yes, how often do these episodes occur? \_\_\_\_\_

Since the first one, are they becoming more frequent?  Yes  No

Since the first one, are they becoming less frequent?  Yes  No

How long do these symptoms last? \_\_\_\_\_

Describe a typical episode: \_\_\_\_\_

Have you experienced nausea or vomiting?  Yes  No  
If yes, how often? \_\_\_\_\_  
If yes, do you think it is related to your dizziness? \_\_\_\_\_

Does anything make your symptoms worse?  Yes  No  
If yes, what? \_\_\_\_\_

Does anything make your symptoms better?  Yes  No  
If yes, what? \_\_\_\_\_

Are you having any symptoms now?  Yes  No  
If yes, what? \_\_\_\_\_

When was your last episode of dizziness? \_\_\_\_\_

**Please answer the following questions:**

- Do loud noises cause your dizziness?  Yes  No
- If you have an earache, are you also dizzy at that time?  Yes  No
- Do you think your dizziness is related to your menstrual periods?  Yes  No  N/A
- Do you think your dizziness is related to changes in weather?  Yes  No
- Do you think that stress make your dizziness worse?  Yes  No
- Is your dizziness worse when you are tired?  Yes  No

**The following information will help us understand your symptoms. Please check those items that describe your symptoms and circle words in parentheses as needed.**

- You are off balance.  when dizzy  when not dizzy
- You are lightheaded.  when dizzy  when not dizzy
- You have sensation of falling (right/left) (constantly/occasionally).  when dizzy  when not dizzy
- Changes in body position increase the dizziness
- If yes, check those that apply:**
- Turning to the (right/left) while standing increases the dizziness
- Bending over (forward/backward) increases the dizziness
- (Sitting up/Standing up) increases the dizziness
- Turning to the (right/left) while lying down increases the dizziness
- Changes in head position increase the dizziness
- If yes, then:  Turning your head to the (right/left) increases the dizziness
- Do you ever feel dizzy when you are (looking up/looking down)?
- While walking on level surfaces do you veer to the (right/left)?  when dizzy  when not dizzy

**Please check all that apply:**

- Changing direction increases my dizziness.
- Walking around corners increases my dizziness.
- Walking in the dark increases my dizziness.
- Walking up/down stairs increases my dizziness.
- Riding in elevators increases my dizziness.
- Riding up/down escalators increases my dizziness.
- Walking in shopping malls increases my dizziness.
- It bothers me to have people stand too close to me.  when dizzy  when not dizzy
- Ladders and/or heights bother me.  all my life  new problem
- Driving a car bothers me (in the daytime/at night)  all my life  new problem
- Riding in a car bothers me (in the daytime/at night)  all my life  new problem
- Riding or driving through tunnels/over bridges/around curves bothers me.  all my life  new problem
- Riding in an airplane bothers me.  all my life  new problem
- Riding in a boat bothers me.  all my life  new problem

**Check all that apply:**

- I would describe my gait as steady.
- I would describe my gait as unsteady.
- I use a cane, a walker, or a wheelchair.
- I have fainted or blacked out.
- I have difficulty reading or writing.
- I have difficulty with my speech.
- I have difficulty reading in a car.
- I have sudden spontaneous falls while standing or walking, with complete recovery in seconds or minutes. There is no recognized loss of consciousness and I remember it afterwards. (drop attacks)
- I experience blurring of vision or double vision.
- I have problems with depth perception.
- I have short term memory loss.
- I have difficulty concentrating.

**Ear & Hearing History**

- Do you experience tinnitus (noise in your ear(s))?  Yes  No  
If yes, what it does sound like? \_\_\_\_\_  
If yes, which ear?  Right  Left  Both  
If yes, is it occasional or all of the time?  Occasional  All of the time  
How bad is it?  Not bad  A little bothersome  Bothersome  Very bothersome
- Do you experience pressure/fullness in your ear(s)?  Yes  No  
If yes, which ear?  Right  Left  Both
- Do you ever feel any numbness or tingling in or around your ear?  Yes  No  
If yes, which ear?  Right  Left  Both  
If yes, is it occasional or all of the time?  Occasional  All of the time
- Does your hearing fluctuate with the dizzy episodes?  Yes  No  
If yes, which ear?  Right  Left  
If yes, was the hearing loss gradual or sudden?  Gradual  Sudden
- Has your hearing ever improved?  Yes  No  
Have you experienced loud noise exposure in the past?  Yes  No  
If yes, please describe the type of noise and duration \_\_\_\_\_
- Do you experience loud noise exposure at work?  Yes  No  
If yes, how many hours per day? \_\_\_\_\_
- Do you shoot guns?  Yes  No  
If yes, do you shoot a pistol, rifle or shotgun?  Pistol  Rifle  Shotgun  
If yes, do you use ear protection?  Yes  No  
What type? \_\_\_\_\_
- Have you ever had any ear infections, earaches, or ear pain?  Yes  No  
If yes, which ear?  Right  Left  Both  
If yes, occasionally or all of the time?  Occasional  All of the time
- Do you have a hole in your eardrum?  Yes  No  
If yes, which ear?  Right  Left
- Have you had any ear operations?  Yes  No  
If yes, please describe. \_\_\_\_\_

### Lifestyle

Do you drink alcohol?  Yes  No  
 If yes, how many drinks per day? \_\_\_\_\_

Do you smoke?  Yes  No  
 If yes, how many cigarettes/packs per day? \_\_\_\_\_

Have you smoked in the past  Yes  No  
 If yes, when did you quit? \_\_\_\_\_

Do you consume caffeinated beverages?  Yes  No  
 If yes, how many of the following beverages do you consume per day:

Cups of Coffee \_\_\_\_\_  Cups of cocoa \_\_\_\_\_  
 Cups of Tea \_\_\_\_\_  Soda/Pop \_\_\_\_\_

Do you think you consume a lot of sugar?  Yes  No  
 Do you think you consume excessive salt?  Yes  No  
 On average, how many hours of sleep do you get each night? \_\_\_\_\_

Do you feel that you have insomnia?  Yes  No  
 Do you exercise?  Yes  No  
 If yes, how many time per week? \_\_\_\_\_  
 If yes, for how long? \_\_\_\_\_  
 If yes, what type of exercise? \_\_\_\_\_

### Medications

**Please list all of your current medications, including hormones, birth control pills, vitamins, etc. Please include the name of the medication, dosage, and times taken per day.**

Name	Dosage	# Times per Day

**What medications have you taken for your dizziness?**

Name	Dosage	#Times/day	Did it help?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

**List any allergies to medications:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Past Medical History**

**Please check those items you have experienced and dates:**

- |   |  |
|---|--|
| <input type="checkbox"/> Low back pain                    | <input type="checkbox"/> Neck injury                 |
| <input type="checkbox"/> Neck pain                        | <input type="checkbox"/> Whiplash                    |
| <input type="checkbox"/> Foot Problems                    | <input type="checkbox"/> Cardiac surgery             |
| <input type="checkbox"/> Ankle sprain/fracture            | <input type="checkbox"/> TMJ                         |
| <input type="checkbox"/> Knee injury                      | <input type="checkbox"/> Jaw pain                    |
| <input type="checkbox"/> Hip injury                       | <input type="checkbox"/> Recent dental work          |
| <input type="checkbox"/> Concussion                       | <input type="checkbox"/> Arthritis                   |
| <input type="checkbox"/> Head injury                      | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Loss of consciousness            | <input type="checkbox"/> Seizure                     |
| <input type="checkbox"/> Headaches                        | <input type="checkbox"/> Convulsion                  |
| <input type="checkbox"/> Migraines                        | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Unusual Stress              |
| <input type="checkbox"/> Low blood sugar                  | <input type="checkbox"/> Panic Attacks               |
| <input type="checkbox"/> High cholesterol                 | <input type="checkbox"/> Treatment by a specialist   |
| <input type="checkbox"/> Eye problem                      | <input type="checkbox"/> Treatment by a psychologist |
| <input type="checkbox"/> Irregular heartbeat (arrhythmia) | <input type="checkbox"/> Heart attack                |

**Have you had any of the following? (Please check all that apply.)**

- |   |  |
|---|--|
| <input type="checkbox"/> Mononucleosis    | <input type="checkbox"/> Blood transfusion in the last 5 years |
| <input type="checkbox"/> Epstein Barr     | <input type="checkbox"/> Insect Bites                          |
| <input type="checkbox"/> Syphilis         | <input type="checkbox"/> Tick Bites                            |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Mumps                                 |
| <input type="checkbox"/> Exposure to HIV  | <input type="checkbox"/> Measles                               |
| <input type="checkbox"/> Exposure to AIDS | <input type="checkbox"/> Meningitis                            |
| <input type="checkbox"/> Polio            |  |

**If you have any relatives with the following, please describe the relationship:**

- |   |   |
|---|---|
| <input type="checkbox"/> Migraine headaches   | <input type="checkbox"/> Heart Disease        |
| <input type="checkbox"/> Meniere's Disease    | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Vertigo or Dizziness | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Balance Problems     | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Neurological Disease |

## **Previous Tests**

**Please include the date of test, where the test was performed, and the results of the testing.**

- Hearing Test
- E/VNG (Electro/Videonystagmography)
- MRI (Magnetic Resonance Imaging)
- CAT Scan
- BAER/ABR (Brainstem Auditory Evoked Response/Auditory Brainstem Response)
- OAE (Otoacoustic Emission)
- Balance Platform Test (Posturography)
- Rotary Chair Test
- VAT (Vestibular Autorotation Test)
- ECOG (Electrocochleography)
- Neck X-rays
- Carotid Artery Doppler Flow Study
- Lumbar Puncture (Spinal Fluid Study)
- Neurology Evaluation
- Complete Physical