Coastal Carolina Otolaryngology
COA

PRETEST INSTRUCTIONS FOR VIDEO-NYSTAGMOGRAPHY (VNG)

You have been scheduled to have special testing to determine the cause of your symptoms. This information is necessary for us to reach a diagnosis and determine the proper course of treatment for you. The balance system consists of input from three pathways—the eyes, or visual pathway; the proprioceptive pathway, or the sense of where your body is in space; and the ears, or vestibular pathway.

VIDEO-NYSTAGMOGRAPHY: This test is done to determine the condition of the balance portion of the inner ear. It helps in diagnosing the cause of dizziness and related conditions. The VNG takes about one hour. Please dress comfortably and ***DO NOT WEAR EYE MAKEUP.*** This test consists of three parts—a visual tracking test that measures movements of the eyes as they follow a target, positional testing and caloric tests that measure the functionality of your inner ear system.

48 HOURS PRIOR TO TESTING: Discontinue the following medications if new within the last year (consult your prescribing physician if you have any concerns).

ANTI-NAUSEA: Compazine, Dramamine®, Phenergan, Atarax, Thorazine, etc.

ANTI-VERTIGO: Antivert, Meclizine, Bonine®, Robinul, Dramamine®, MotionEaze, Unisom®, Scopolamine patch, etc.

ANTI-DEPRESSANTS, ANTI-ANXIETY: Xanax, Valium, Librium, Vistaril, Serax, Ativan, Librax, TRANXENE®, EFFEXOR XR®, Diazepam, Zoloft, Paxil, Wellbutrin, Lexapro, Prozac, Lorazepam, Cymbalta, Clonazepam, Ambien, Lunesta

NARCOTICS & BARBITUATES: Demerol, Phenaphen, TYLENOL® with Codeine, Darvocet, Oxycodone, Percocet

ANTI-HISTAMINES: Actifed, BENADRYL®, Chlor-Trimeton, Dimetane, Disophrol, Teldrin, Triaminic®, Claritin®, Clarinex, ZYRTEC®, Allegra®, Astelin and other over-the-counter cold remedies

HERBS: Melatonin, Ephedra, Mu Huang, Ginkgo, St. John's Wort, Kava, Valerian

ANY SUBSTANCE THAT AFFECTS THE CENTRAL NERVOUS SYSTEM

ALCOHOL in any quantity, including beer, wine and cough medicines with alcohol

24 HOURS before testing, avoid caffeine (coffee, tea and sodas), tobacco products and cigarettes

If you are unable to follow these instructions, please call us prior to the testing or inform us when you arrive for the testing. It affects our interpretation of the test results.

DO NOT EAT ANYTHING FOUR HOURS BEFORE TESTING. If you have any questions, call the audiology department at (843) 449-6449.

Your appointment time is ______________, ____________________ at __________________.
(Day) (Date) (Time)

3822 Mayfair Street, Myrtle Beach, SC 29577 | **Phone: (843) 449-6449**
1120 Glenns Bay Road, Suite 117, Surfside Beach, SC 29575 | **Phone: (843) 215-1068**

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Vestibular Medical History Questionnaire

Name: ______________________________ Date of Birth: ____________

Today's Date: ____________ ENT/Physician Referred: ______________________________

Initial Onset

Describe what happened the first time you experienced dizzy/imbalance symptoms:

Symptoms

Please check all that apply.

- ☐ Dizziness
- ☐ Visual changes
- ☐ Falling
- ☐ Hearing loss
- ☐ Fatigue
- ☐ Nausea/Vomiting
- ☐ Spinning
- ☐ Double vision
- ☐ Lightheadedness
- ☐ Headache
- ☐ Brain fog
- ☐ Noise in ears
- ☐ Fullness, pressure or pain in ears
- ☐ Unsteadiness
- ☐ Rocking/Tilting
- ☐ Fainting

History of Present Illness

Describe your current problem:

When did your problem start (date)? ______________________________

Was it associated with a related event (e.g., head injury)? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

Was the onset of your symptoms ☐ Sudden ☐ Gradual ☐ Overnight ☐ Other

Please describe: ______________________________

Are your symptoms ☐ Constant ☐ Variable (i.e., come and go in spells)

If variable:

The spell occurs every number of: ________ Hours ________ Days ________ Weeks

________ Months ________ Years

The spell lasts ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Do you have any warning signs that a spell is about to happen? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

Are you completely free of symptoms between spells? ☐ Yes ☐ No

Do your symptoms occur when changing positions? ☐ Yes ☐ No

If yes, check all that apply:

☐ Rolling your body to the left
☐ Rolling your body to the right
☐ Moving from a lying to a sitting position
☐ Looking up with your head back
☐ Turning head side to side while sitting/standing
☐ Bending over with your head down

Is there anything that makes your symptoms better? ☐ Yes ☐ No

If yes, please explain: ______________________________

Is there anything that makes your symptoms worse? ☐ Yes ☐ No

If yes, check all that apply:

☐ Moving your head
☐ Riding/Driving in a car
☐ Loud sounds
☐ Standing up
☐ Time of day
☐ Physical activity or exercise
☐ Large crowds or busy environments
☐ Coughing, blowing nose
☐ Eating certain foods
☐ Stress

When you have symptoms, do you need to support yourself to stand or walk? ☐ Yes ☐ No

If yes, how do you support yourself? ______________________________

Have you ever fallen as a result of your current problem? ☐ Yes ☐ No

Do you have a history of any of the following? Check all that apply.

☐ Migraines
☐ Multiple sclerosis
☐ Panic attacks/Anxiety
☐ Glaucoma
☐ Seizures
☐ Neuropathy
☐ Depression
☐ Macular degeneration
☐ Tumor
☐ Congestive heart failure
☐ Cervical spine arthritis
☐ Parkinson's disease
☐ Stroke
☐ Concussion
☐ Diabetes mellitus
☐ Ataxia

Has there been a recent change in your vision, including contacts or glasses? ☐ Yes ☐ No

Describe any ear-related symptoms.

Do you have any difficulty with hearing? ☐ Yes ☐ No

If yes, which ear(s)? ☐ Left ☐ Right ☐ Both

When did this start? ______________________________

Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? ☐ Yes ☐ No

When you are walking, do you: ☐ Veer left? ☐ Veer right? ☐ Remain on a straight path?

Habits

Please describe your habits in regard to the following substances:

Caffeine
☐ I do not consume caffeine.
☐ I consume caffeine.

I drink __________ cups of __________________ (e.g., coffee) per ___________________________ (time period).

Tobacco

☐ I do not consume tobacco.

☐ I consume tobacco.

I smoke/chew ________ (amount) of ________________ (product) per ________________________ (time period).

Alcohol

☐ I do not consume alcohol.

☐ I consume alcohol.

I drink ________ glasses of ________________ (e.g., wine) per _____________________________ (time period).

Recreational drug use

☐ I do not use drugs.

☐ I use ____.

How many times per day? ________ For how many years? ____

Medications

☐ I do not take any medications.

☐ I take the following medications.

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