Videonystagmography (VNG) Test Information

You have been scheduled for Videonystagmography (VNG) testing on ____________________________, at ____________ AM/PM.

The VNG test is designed to give your physician information regarding the source of your dizziness/vertigo/imbalance. The test requires one hour of your time for completion. Throughout the test you will be wearing infrared goggles that will record your eye movements. The test is composed of three main parts: (1) Tracking (following a light with your eyes); (2) Sitting and laying in different head and body positions; and (3) Introducing warm and cool air to each ear. Portions of the test may induce a sensation of vertigo, but this effect is brief and temporary.

You will not have the VNG results immediately. A follow-up appointment will be made for you after your test for you to discuss the results with your physician. **We recommend that you have someone drive you to and from your appointment in case you experience dizziness from this test.**

Important Pre-Test Instructions for VNG Testing- PLEASE READ CAREFULLY

- Do not drink coffee, tea, soda or any beverage containing caffeine for 4 hours prior to the test.
- Do not eat 4 hours before the test. Parts of the test may cause nausea. If you are diabetic and need to eat in the hours prior to testing, please keep the meal light.
- Do not smoke 4 hours before the test.
- Do not drink any type of alcohol within 48 hours of the test.
- Face must be completely free of makeup.
- Dress comfortably.

The following medications must not be taken for at least 48 hours before the test (if you are unsure, please call 715-930-1940)

- Pain medications
- Anti-anxiety medications
- Anti-vertigo medication
- Anti-nausea medication
- Allergy medication
- Sleep medication
- Diuretics/water pills

Please continue to take any heart, blood pressure, diabetic, thyroid, and seizure medications, or any medication deemed necessary by your physician prior to testing.

<u>**If you forget and take any of the above medications in the 48 hours prior to your appointment, or ingest caffeine 4 hours before your appointment, we will be UNABLE to perform the test, and will need to reschedule your appointment to obtain reliable results.**</u>

Patient History

Fill out form even if you are not currently experiencing symptoms.

1. Describe your dizziness: Check all that apply

☐ Dizziness
☐ Sensation of movement
☐ Difficulty moving around
☐ Spinning sensation
☐ Loss of balance

2. Associated Symptoms:

a. Hearing loss	☐ Yes (*if yes answer questions below*)	☐ No (Skip to b.)
Onset:	☐ Gradual ☐ Sudden	
Location:	☐ Both ears ☐ Right ear	☐ Left ear
Does your hearing ability change/fluctuate? If Yes please describe:		
Trigger/Cause:		
b. Nausea	☐ Yes (*If yes answer questions below*)	☐ No (Skip to c.)
When does this occur?		
Does anything make your nausea better? Worse? If Yes please describe:		
c. Vomiting	☐ Yes (*If yes answer questions below*)	☐ No (Skip to 3)
If Yes please describe:		
Does anything make your vomiting better? Worse? If Yes please describe:		

3. When did your first episode of dizziness occur?

_______________ Days ago _______________ Months ago _______________ Years ago

4.Occurred with the onset of your dizziness: Check all that apply

☐ Viral illness
☐Head trauma
☐ Upper respiratory infection
☐ Ear trauma
☐ Ear infection
☐ Other: _______________

5. How often do your symptoms occur?

☐Hourly _______ Per hour
☐Weekly _______ Per week
☐Daily _______ Per day
☐Monthly _______ Per month

6. How long do your Symptoms last?

☐ _______ Minutes
☐ _______ Days
☐ _______ Hours
☐ _______ Months
☐ Constant
☐ Other: _______________

7. Severity Level

☐Mild ☐Moderate ☐Severe

8. Progression Level

☐ Worsening
☐ Improving
☐ Resolved
☐ Unchanged ☐ Other: _______________

9. What makes your dizziness worse? Check all that apply

☐ Nothing
☐ Looking up
☐ Rolling over
☐ Head movement
☐ Bending over
☐ Straining
☐ Turning head direction: _______________
☐ Lying down
☐ Standing
☐ Flexing neck
☐ Other:

10. What makes your dizziness better? Check all that apply

☐ Nothing
☐ Lying still
☐ Rest
☐ Avoiding head movement
☐ Medicine: _______________
☐ Other: _______________

11. Other Symptoms not listed:

12. Current treatment:

- ☐ None
- ☐ Medicine: ____________________
- ☐ Salt restriction
- ☐ Vestibular exercise
- ☐ Other: ____________________

13. Medical History: Check all that apply

- ☐ Meniere's Disease
- ☐ Migraine
- ☐ Cerebrovascular disease

Have you been exposed to any of the following: Check all that apply

- ☐ Aminoglycosides (antibiotics)
- ☐ Ototoxic drugs
- ☐ Chemotherapeutic agents
- ☐ Carbon monoxide

Family History: Check all that apply

- ☐ Migraine
- ☐ Vertigo
- ☐ Other: ____________________

Activities Balance Confidence Scale

Name: ____
DOB: ____
DOS: ____

Audiologist: Dr. Emily Barquest
Location: ___________________

Instructions: Indicate your level of confidence while performing the activities below without losing balance or becoming unsteady. If you normally use a walking aid to do the activity, or if you hold onto someone, rate your confidence as if you were using these supports. Use the percentage scale:

No Confidence 0% 20% 40% 60% 80% 100% Complete Confidence

How confident are you that you will not lose balance or become unsteady when you: *(check one)*

	0%	20%	40%	60%	80%	100%
Walk around the house?	☐	☐	☐	☐	☐	☐
Get into or out of a car?	☐	☐	☐	☐	☐	☐
Walk up or down stairs?	☐	☐	☐	☐	☐	☐
Walk across a parking lot?	☐	☐	☐	☐	☐	☐
Bend over to pick up something from the floor?	☐	☐	☐	☐	☐	☐
Walk up or down a ramp?	☐	☐	☐	☐	☐	☐
Reach for something off a shelf at eye level?	☐	☐	☐	☐	☐	☐
Walk in a crowded mall while others walk past you?	☐	☐	☐	☐	☐	☐
Stand on tiptoes to reach for something high?	☐	☐	☐	☐	☐	☐
Are bumped into by other people at the mall?	☐	☐	☐	☐	☐	☐
Stand on a chair and reach for something?	☐	☐	☐	☐	☐	☐
Step on or off an escalator while holding onto the railing?	☐	☐	☐	☐	☐	☐
Sweep the floor?	☐	☐	☐	☐	☐	☐
Step on or off an escalator while not holding on?	☐	☐	☐	☐	☐	☐
Walk outside the house to a car in the driveway?	☐	☐	☐	☐	☐	☐
Walk on snowy and icy surfaces?	☐	☐	☐	☐	☐	☐

Dizziness Handicap Inventory (DHI)

Name: ____
DOB: ____
DOS: ____

Audiologist: Dr. Emily Barquest
Location: ___________________

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

	Question	Yes	No	Sometimes
1P	Does looking up increase your problem?	☐	☐	☐
2E	Because of your problem, do you feel frustrated?	☐	☐	☐
3F	Because of your problem, do you restrict your travel for business or recreation?	☐	☐	☐
4P	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
5F	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
6F	Does your problem significantly restrict your participation in social activities? (e.g. going out to dinner, the movies, dancing, or parties?)	☐	☐	☐
7F	Because of your problem, do you have difficulty reading?	☐	☐	☐
8P	Does performing more ambitious activities increase your problem? (e.g. sports, dancing, or household chores such as sweeping or putting away dishes?)	☐	☐	☐
9E	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
10E	Because of your problem, are you embarrassed in front of others?	☐	☐	☐
11P	Do quick movements of your head increase your problem?	☐	☐	☐
12F	Because of your problem, do you avoid heights?	☐	☐	☐
13P	Does turning over in bed increase your problem?	☐	☐	☐
14F	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
15E	Because of your problem, are you afraid people may think you are intoxicated?	☐	☐	☐
16F	Because of your problem, is it difficult for you to walk by yourself?	☐	☐	☐
17P	Does walking down a sidewalk increase your problem?	☐	☐	☐
18E	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
19F	Because of your problem, is it difficult for you to walk around the house in the dark?	☐	☐	☐
20E	Because of your problem, are you afraid to stay at home alone?	☐	☐	☐
21E	Because of your problem, do you feel handicapped?	☐	☐	☐
22E	Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
23E	Because of your problem, are you depressed?	☐	☐	☐
24F	Does it interfere with your job or household responsibilities?	☐	☐	☐
25P	Does bending over increase your problem?	☐	☐	☐
		X4	**X0**	**X2**
	Score:			
	Total:			

For Office Use Only: P=	E=	F=
☐100-70 = severe perception of having a handicap	☐ 69-40 = moderate perception of handicap	☐ 39-0 = low perception of handicap