SHOHET EAR ASSOCIATES
MEDICAL GROUP, INC.

Videonystagmography (VNG)

Videonystagmography (VNG) is used clinically to evaluate patients with dizziness, vertigo, or balance dysfunction. VNG provides an objective assessment of the oculomotor and vestibular systems, which are responsible for monitoring head movements and position in order to stabilize retinal images. During the test, you will wear infrared goggles while your clinician uses video-oculography to record eye movements.

VNG consists of three parts: oculomotor evaluation, positioning/positional testing, and caloric stimulation. These tests assess the systems responsible for rapid eye movements, fixation, tracking targets in the visual field, and central integration of vestibular information. Subtests reveal the presence or absence of nystagmus associated with benign paroxysmal positional vertigo (BPPV), the presence or absence of nystagmus in various body positions, and side of lesion in cases of peripheral vestibular weakness. Analyses of test results assist in determining the source of your dizziness or unsteadiness.

You have been scheduled for Videonystagmography (VNG) on _____, at _____.
The test requires 60-90 minutes to complete. Although some people experience dizziness during the test, the dizziness is of short duration and should subside upon completion of the test.

IN ORDER TO ACHIEVE THE BEST TEST RESULTS, YOU SHOULD CAREFULLY FOLLOW THESE INSTRUCTIONS:

1. Clean face, no makeup.
2. Remove contact lenses before the examination (bring your eyeglasses).
3. No solid foods for **2 to 4 hours** before the test.
4. No aspirin or medication containing aspirin for **48 hours** before the test.
5. No alcoholic beverages, liquid medication containing alcohol, or smoking **48 hours** before the test.
6. Discontinue all medication for **48 hours** prior to the test, except "maintenance" medications for your heart, blood pressure, diabetes, or seizures, and any medications deemed by your physician to be necessary. Please consult physician for clarification.

THE FOLLOWING MEDICATIONS SHOULD BE DISCONTINUED <u>48 HOURS</u> PRIOR:

- Allergy pills
- Decongestants/Antihistamines (Benadryl, Sudfed, Dimetapp, Chlortrimeton, Seldane)
- Tranquilizers (Valium, Libruim, Xanax, Ativan, etc.)
- Sedative pills (all sleeping pills or tranquilizers)
- Antidepressants (Prozac, Zoloft, Wellbutrin, etc.)
- Pain pills
- Diet pills
- Nerve/muscle relaxant pills (Robaxin, Valium, etc.)
- Dizziness pills (Antivert, Meclizine, Bonine, ear patches, etc.)
- Aspirin or aspirin substitutes (Tylenol, etc.)
- Narcotics/Barbiturates (Codeine, Demerol, Percodan, Phenobarbital, antidepressants)

<u>Note</u>: It is helpful if you bring a list of the medications you take regularly, or even medications themselves. Medications can be resumed immediately following the ENG testing procedures. **If there are any questions about the test or medication, please contact your doctor or our office at (562)270-4327**

The following is a partial list of medications that affect the results of the VNG and should be discontinued 48 hours prior to testing. Medications can be resumed immediately following the VNG testing procedures. **If there are any questions regarding your medications, please contact our Newport Beach office at (949) 631-4327 or our Seal Beach office at (562)-270-4327**

- Drug Class: Opiods
  - **Vicodin/OxyContin/Lortab/Norco** (hydrocodone)
  - **Ultram/Ultracet** (Tramadol HCL)
  - **Roxanol** (Morphine Sulfate)
  - **Darvocet/Darvon** (Propoxyphene NAP)
  - **Codeine** (Codeine Phosphate)
  - **Methadone/Dolophine** (Methadone HCL)
  - **Sublimaze**/Duragesic/Actiq (Fentanyl)
  - **Demerol** (Meparidine)
  - **Dolophine** (Methadone)

- Drug Class: Salicilates
  - **Aspirin/Bayer/Acuprin/Aspergum** (Aspirin)

- Drug Class: Benzodiazepines
  - **Xanax** (Alprazolam)
  - **Valium** (Diazepam)
  - **Ativan** (Lorazepam)
  - **Zyprexa** (Olanzapine)
  - **Klonopin** (Clonazepam)
  - **Seroquel** (Quetiapine Fumarate)

- Drug Class: Stimulants
  - **Adderall SR** (Amphetamine Mixed Salts)
  - **Ritalin** (Methylphenidate HCL)
  - **Strattera** (Atomoxetine)

- Drug Class: Antidepressants
  - **Prozac** (Fluoxetine)
  - **Lithotab/Lithonate/Eskalith** (Lithium Carbonate)
  - **Effexor XR** (Venlafaxine HCL)
  - **Zoloft** (Sertrline)
  - **Paxil** (Paroxetine HCL)
  - **Zyban/Wellbutrin** (Bupropion HCL) *also used to quit smoking
  - **Celexa** (Citalopram Hydrobromide)
  - **Remeron** (Mirtazapine)
  - **Elavil** (Amitriptyline)

- Drug Class: Sedatives
  - **Ambien** (Zolpidem Tartrate)
  - **Abililfy** (Aripiprazole)
  - **Lunesta** (Eszopiclone)

- Drug Class: Muscle Relaxants
  - **Soma** (Carisoprodol)
  - **Skelaxin** (Metaxalone)
  - **Zanaflex** (Tizanidine)

- Drug Class: Vestibular Supressants
  - **Meclizine/Antivert/Bonine** (Meclizine)
  - **Benadryl** (diphenhydramine)

Patient Name: _____ DOB:____/____/____ Sex: M F Date:_____

The following questions refer to your feeling of dizziness. Please answer them as "yes" or "no" and fill in all blanks.

Please describe in your own words, the sensation you feel without using the word "dizzy":

_____

_____

_____

1. **Do you ever have any of the following sensations? (circle yes or no)**
   - Spinning in circles…….. Yes No
   - Falling to one side...……...…….. Yes No
   - World spinning around you…… Yes No
2. **The following refer to a typical dizzy spell (circle yes or no):**
   - Do the dizzy spells come in attacks?..... Yes No
     - How often? _____
     - How long? _____
     - Date of first spell? _____
   - Are you free from dizziness between attacks?..... Yes No
   - Does your hearing change with an attack?..... Yes No
   - Are you dizzy mainly when you sit or stand up quickly?..... Yes No
   - Are you more dizzy in certain positions?..... Yes No
     - Which positions? _____
   - Are you nauseated during an attack?..... Yes No
   - Are you dizzy even when lying down?..... Yes No
   - Have you had a recent cold or flu preceding recent dizzy spells?..... Yes No
   - Have you had fullness, pressure or ringing in your ears?..... Yes No
   - Have you had pain or discharge in your ear of recent onset? ..... Yes No
   - Have you had trouble walking in the dark?..... Yes No
   - Are you better if you sit or lie perfectly still?..... Yes No
3. **The following refer to other sensations you may have (circle yes or no):**
   - Do you black out or faint when dizzy?..... Yes No

   Have you had:
   - Severe or recurrent headaches?..... Yes No
   - Any double or blurry vision?..... Yes No
   - Numbness in you face or extremities?..... Yes No
   - Weakness or clumsiness in arms, legs?..... Yes No
   - Slurred or difficult speech?..... Yes No
   - Difficulty swallowing?..... Yes No
   - Tingling around your mouth?..... Yes No
   - Spots before your eyes?..... Yes No
   - Jerking of arms or legs?..... Yes No
   - Seizures?..... Yes No
   - Confusion or memory loss?..... Yes No
   - Motion sickness?..... Yes No

Recent head trauma? (if yes, explain)..... Yes No

_____

_____

_____

4. The following refer to your hearing. Indicate which side has been affected:

Difficulty hearing in one ear?..... Left Right Both No
Ringing in one ear?..... Left Right Both No
Fullness in one ear?..... Left Right Both No
Change in hearing when dizzy?..... Yes No
If yes, how? _____

Have you had any of the following?

Pain in ears?..... Left Right Both No
Discharge from ears?..... Left Right Both No
Hearing change? Yes No
Better?..... Left Right Both No
Worse?..... Left Right Both No
Exposure to loud noises?..... Yes No
Previous ear infections?..... Yes No
Previous ear surgery?..... Yes No
What? _____
Family history of deafness?..... Yes No

5. The following refer to habits and lifestyle (circle yes or no):

Is there added stress in your life recently?..... Yes No
Are you dizzy or unsteady constantly?..... Yes No

Is your dizziness related to:

Moments of stress?..... Yes No
Menstrual period?..... Yes No
Overwork or exertion?..... Yes No
Do you feel lightheaded or have swimming sensation when you are dizzy? Yes No
Do you find yourself breathing faster or deeper when excited or dizzy? Yes No
Did you recently change eyeglasses?..... Yes No
Have you ever had weakness or faintness a few hours after eating? Yes No
Do you drink coffee?..... Yes No
How much? _____
Do you drink tea?..... Yes No
How much? _____
Do you drink soft drinks?..... Yes No
How much? _____
Do you drink alcohol?..... Yes No
How much? _____

Do you smoke?..... Yes No

What? _____

How much? _____

Past Medical History:

Please list your current medical problems and length of illness:

Please list all surgery performed and approximate dates:

Please list all allergies (including drugs) and reaction:

Please list all medicines you currently take (including pain medicine, nonprescription medicine, nerve pills, sleeping pills, or birth control pills):

Family History:

Any family history of (circle yes or no):

High blood pressure?.....	Yes	No
Low blood pressure?.....	Yes	No
Diabetes?.....	Yes	No
Low blood sugar?.....	Yes	No
Thyroid disease?.....	Yes	No
Asthma?.....	Yes	No
Miagraines?.....	Yes	No

Please list any other diseases that run in your immediate family:

System review - Check all applicable symptoms:

Constitutional:

☐ Recent weight change ☐ Fever ☐ Fatigue ☐ N/A

Eyes:

☐ Loss of vision ☐ Pain ☐ Discharge/Tearing ☐ N/A
☐ Left ☐ Right ☐ Both ☐ Left ☐ Right ☐ Both ☐ Left ☐ Right ☐ Both

Ears, Nose, Mouth, Throat:

☐ Itchy ears ☐ Nasal discharge ☐ Nasal obstruction ☐ Sneezing
☐ Facial weakness ☐ Nosebleed ☐ "Stuffy" nose ☐ Snoring
☐ Loss of sense of smell ☐ Growth in nose ☐ Lump in Neck ☐ Drooling
☐ Mouth growth, ulcer ☐ Chewing difficulty ☐ Dental problems ☐ Sore throat
☐ Paint on swallowing ☐ Bleeding from throat ☐ Voice Changes ☐ Heartburn
☐ Breathing difficulty ☐ N/A

Cardiovascular:

☐ Leg pain with walking ☐ Swelling of legs ☐ Irregular heart beat ☐ Chest pain
☐ Leg pain with resting ☐ N/A

Respiratory:

☐ Wheezing ☐ Cough ☐ Shortness of breath ☐ Mucus
☐ Coughing up blood ☐ N/A

Gastrointestinal:

☐ Decrease in appetite ☐ Nausea/Vomiting ☐ Blood in stool ☐ Indigestion
☐ Difficulty swallowing ☐ Diarrhea/constipation ☐ Food intolerance ☐ N/A

Musculoskeletal:

☐ Neck pain ☐ Joint pain/stiffness ☐ Arthritis ☐ N/A

Skin:

☐ Rash ☐ Jaundice ☐ Recent baldness ☐ N/A

Neurologies:

☐ Headache ☐ Blackout ☐ Seizures ☐ Paralysis
☐ Tremor ☐ N/A

Psychiatric:

☐ Insomnia ☐ Depression ☐ On medications? ☐ N/A
☐ Yes ☐ No

Endocrine:

☐ Thyroid trouble ☐ Heat or cold intolerance ☐ Excessive sweating
☐ Excessive thirst, hunger, urination ☐ N/A

Genitourinary:

☐ Painful urination ☐ Venereal disease ☐ Blood in urine
☐ Incontinence ☐ Difficulty passing urine ☐ N/A

Hermatologic/Lymphatic:

☐ Blood disorder ☐ Bleeding problems ☐ Easy bruising ☐ Anemia

Do you have anything else to tell us about your particular problem which we have not asked you on this questionnaire?