FLORIDA ENT ADULT & PEDIATRIC, PA

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LOCATIONS: * 400 Celebration Place, Suite 340
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OTOLARYNGOLOGY – HEAD & NECK SURGERY – EAR & SINUS SURGERY – FACIAL PLASTIC & SKIN CANCER SURGERY – THYROID SURGERY

VNG INSTRUCTIONS

∗Please make sure you read instructions and answer all questions.∗

You have been scheduled for Videonystagmography (VNG) testing on
________________________________, at_____________AM
The VNG/ENG 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. Please **arrive 10 minutes early** for your appointment. If you arrive more than **fifteen (15) minutes** late we will reschedule your appointment.

The test has three main parts:
(1) Tracking (following a light with your eyes);
(2) Sitting and laying in different head and body positions; and
(3) "Irrigating" each ear with warm and cool air. Throughout the test you will be wearing infrared goggles that will record your eye movements. Portions of the test may induce a sensation of vertigo, but this effect is brief and temporary. There is no pain or needle sticks from this test.
We recommend that you have someone drive you to and from your appointment in case you experience dizziness from this test.

Pre-Test Instructions :

Note: Following these instructions is imperative to obtain an accurate and reliable Test result. Failure to comply with these instructions may result in rescheduling Your appointment.

1. No alcoholic beverages or any liquid containing alcohol for one day prior To testing.
2. No caffeine, including beverages and medications that include caffeine (for example diet pills), one day prior to testing.
3. Please do not use any form of tobacco on the day of your test.
4. Do not eat for four hours prior to the test. If you must eat for health reasons, Please eat lightly.
5. Your face should be thoroughly washed and clean of make-up of any kind (Including **foundations, *all* eye makeup, contacts, powder, etc**).
6. Dress comfortable.

These they are examples of medicines that you should not take 24 hours before the exam:

Every medicine for the Pain, including:

Codeine (Tylenol, Tylenol P.M., etc..) Aspirin (something with aspirin in it), Codeine (something with codeine in it)
Ibuprofen (Excedrin, Midol, Motrin, etc..) Naproxen (Treacherous) or Darvocet. Nothing recetado for migraine**.**
Every medicine Anti Anxiety, including: Valium/Diazepam, Ativan/Lorazepam, Pamelor/Nortriptyline, Compazine, Xanax, Prozac, and Zoloft.
All medicine Anti-Sickness including: Antivert/Meclizine, the Valium, Phenergan, Dramamine, and Scopolamine
Every tablet of Diets including: Dyazide, Neptazane, Maxide, and Lasix.
All medicine of Dream, including: Ambien, Tylenol P.M. and Halcion.
All medicine of Allergy, including: Antihistaminic and Decongestant.

If you cannot discontinue the medicines for the depression or the anxiety, by please call our office al (407)-343-9006 and to speak with the Nurse.

*You **will not** have the results of the **VNG/ENG** immediately. A follow – up appointment will be made for you to discuss the results with your physician.*

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VESTIBULAR QUESTIONAIRE

** PLEASE MAKE SURE YOU ANSWER ALL THE QUESTIONS BELOW *.*

Name: _________________________ Age: ___ Date: _________Family Doctor: _____________

Circle Yes or No and fill in the blank spaces.

Yes No Do you have any dizziness / Imbalance?
Yes No Do you have any difficulty in hearing?
Yes No Do you have any noise in your ears?
Yes No Do you have any pain in your ears?

Yes No Do you have any discharge from your ears?
Yes No Have you had any MRI/CT of the brain or neck? (If yes we will need the report)
Yes No Do you have any history of anemia, low thyroid, rheumatoid arthritis, lupus, lyme, Low B-12 vitamin, Syphilis, cardiovascular disease or neurological disease?
Yes No Is your dizziness associated with light-headedness or swimming sensation in the head?
Yes No Is your dizziness associated with objects spinning or turning around you?
Yes No Is your dizziness associated with the sensation that you are turning or spinning Inwardly, with the outside objects or remaining stationary?

Describe what you feel during your episode of dizziness / imbalance ________________________________
When did the dizziness / imbalance first occur? ____
How many days per week do you become dizzy / imbalance? ______________________________
When was the last attack? ____
Do you know of any possible cause of your dizziness? ____
Do you know of anything that will stop your dizziness or make it better? ______________________________
Do you know what makes your dizziness worse? ____
How long does an attack last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Circle any **of the following that makes your dizziness worse or precipitate an attack?**
Fatigue, Excretion, Hunger, Menstrual Period, Stress, Emotional Upset, Alcohol

PLEASE TURN OVER

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MD

1. Do you get fluctuating hearing loss? Yes No
2. Do you get low pitch noise in your ears? Yes No
3. Do you get fullness or stuffiness in your ears? Yes No
4. Do you get episodes of dizziness lasting for hours or days? Yes No

VN

1. Did you have any upper respiratory infection prior to the start of your dizziness? Yes No
2. Did the dizziness last for hours or days the first week it occurred? Yes No
3. Is the dizziness slowly improving after the first week? Yes No
4. Is the dizziness worse with moving and better when staying still? Yes No

M.A.D

1. Do you get severe headaches or migraines? Yes No
2. Do you get headaches before, during or after the episode of dizziness? Yes No
3. Do you experience blurred vision? Yes No
4. Do you have any warning that an attack is about to start? Yes No
5. Do you have any nausea or vomiting? Yes No

BPPV

1. Is your dizziness triggered by turning your head to the right or left? Yes No
2. Is your dizziness triggered by looking up or down? Yes No
3. Once your dizziness is triggered, does it usually get's better after a few Seconds or minutes? Yes No

CV

1. Do you have any back of the neck or shoulder pain / muscle spasms? Yes No
2. Do you have any cervical spine abnormalities or arthritis? Yes No

CNSV

1. Have you ever been diagnosed with stroke,CVA,ITA,multiple sclerosis's Seizure disorder or Parkinson's? Yes No
2. Do you have a tendency to fall or have you ever injured your head? Yes No
3. Do you use a cane, walker or wheelchair? Yes No
4. Do you ever completely lose consciences or blackout? Yes No
5. Do you have one sided numbness, weakness, or paralysis of the face, arms or legs? Yes No
6. Do you experience double vision or blindness? Yes No
7. Do you always have poor hand and eye coordination? Yes No
8. Do you have difficulty Swallowing? Yes No