HEAD & NECK
SURGEONS

PHOENIX OFFICE
2222 E Highland Ave.
Suite 204
Phoenix, AZ 85016
Phone (602) 264-4834
Fax (602) 254-5178

SCOTTSDALE OFFICE
6565 E. Greenway Pkwy
Suite 101
Scottsdale, AZ 85254
Phone (480) 948-2056
Fax (480) 659-2544

AHWATUKEE OFFICE
4545 E. Chandler Blvd.
Suite 202
Phoenix, AZ 85048
Phone (480) 659-2330
Fax (480) 659-2544

GLENDALE OFFICE
5750 W. Thunderbird Rd.
Suite A-100
Glendale, AZ 85306
Phone (602) 938-3205
Fax (602) 938-5799

MESA OFFICE
1520 S. Dobson Rd.
Suite 305
Mesa, AZ 85202
Phone (480) 539-4000
Fax (480) 539-7033

VIDEONYSTAGMOGRAPHY (VNG)

Appointment Date_____ Time_____

Videonystagmography (VNG) is a test of your balance system. This test will take approximately 1-1.5 hours and will induce dizziness. Please wear comfortable clothing that is easy to move in while lying down and rolling over.

To obtain valid test results please do the following:

1. **48 hours** prior to the test stop taking the following medications:
   a. Anti-dizzy pills (Meclizine, Antivert, Dramamine)
   b. Tranquilizers, sleeping pills, sedatives
   c. Muscle relaxants
   d. Antihistamines
   e. Anti-depressants
   f. Barbiturates or Narcotics
2. **24 hours** prior to the test avoid:
   a. Caffeine
   b. Alcohol
   c. Smoking
3. Do not eat at least 2 hours prior to the test. A light snack if necessary may be eaten.
4. Do not wear eye make-up (eyeliner and mascara) or contact lenses.

If these directions are not followed, we may need to reschedule your appointment. If you are concerned about not being able to drive afterwards, please make arrangements for someone to drive you.

Please be aware that we require 24 hours advance notice for cancellation of VNG appointments. If you cancel an appointment within 24 hours or miss an appointment, you may be charged a no show/cancellation fee of $25.

If you have any questions, please contact the Audiology Department at (602) 476-5024.

ALWAYS CONSULT YOUR DOCTOR BEFORE STOPPING ANY MEDICATIONS!

Videonystagmography (VNG) Questionnaire

Date:_____

Patient Name:_____ DOB:_____

I. Present illness: I am here because of (circle all that apply)

Dizziness (such as vertigo)

Imbalance

Hearing problem (hearing loss, tinnitus, fullness)

II. Symptoms

My symptoms started on:_____

My symptoms come in: **Attacks** or are **Constant**
If attacks:
How often?_____
How long do they last?_____
Do you have any warning that they are about to start?_____
If so, what_____
Did you have any illness at the time of the initial episode?_____
Were you exposed to any irritating fumes, paints, etc. at the onset of the symptoms?_____
Did you have a neck or head injury?_____

Did/do you experience any of the following while dizzy? (Place an "X" under applicable response)

YES	NO		
___	___	1. Spinning or turning while objects are stationary	
		If yes, does it occur mostly when you	
		___lay down	___roll to the right
		___roll to the left	___look up on to a shelf
___	___	2. Visual blurring or jumping during head motion	
___	___	3. Loss of balance when walking:	
		___veering to the right	___veering to the left
___	___	4. Fall(s):	
		___to the right	___forward
		___to the left	___backward
___	___	5. Swimming sensations in your head	
___	___	6. Light-headedness	
___	___	7. Blacking out or loss of consciousness	
___	___	8. Headache or head pressure	
___	___	9. Nausea or vomiting	
___	___	10. Other:_____	

III. Triggers

Are your dizziness, vertigo, imbalance or hearing problems affected or brought on by:

YES	NO		YES	NO	
___	___	Changes in position of the head or body	___	___	Narrow or wide open spaces
___	___	Standing up	___	___	Exercise
___	___	Rapid head movements	___	___	Foods – salt, MSG
___	___	Walking in a dark room	___	___	Time of day, particular seasons
___	___	Elevators	___	___	Stress
___	___	Airplane, boat, or car travel	___	___	Alcohol
___	___	Loud noises	___	___	Headache/Migraine
___	___	Coughing, blowing your nose or straining	___	___	Menstrual periods (if relevant)
___	___	Other:_____			

IV. Ear Problems

Have you ever had?

1. Loss of hearing? No Right Left Both
2. Abnormal sounds in ear? No Right Left Both
   - Describe the noise_____
   - Does it change when you have symptoms?_____
   - Does anything make the noise better or worse?_____
3. Fullness or pressure in ear? No Right Left Both
4. Pain in ear? No Right Left Both
5. Distortion or sensitivity to sound? No Right Left Both
6. Do you use a hearing aid? No Right Left Both
7. Noise exposure/trauma? No Right Left Both
8. Ear surgery? No Right Left Both

V. Fall Risk

YES	NO	
___	___	Have you fallen in the past six (6) months?
___	___	Have you fallen in the past two (2) years? Amount of falls_____
___	___	If you answered yes to the above, were you injured in any way (skin tear included)? _____
___	___	Are you worried that you may fall?
___	___	Do you have any difficulty rising from a chair?
___	___	Do you have any problems with your feet such as pain or numbness?

VI. Other significant history

Please answer the following questions regarding other possible significant history.

YES	NO	(if yes, please report on onset of symptoms and any current/past treatment)
___	___	Allergies _____
___	___	Diabetes _____
___	___	Migraines_____

a. If so, what are your typical symptoms_____ _____

b. If so, do you take medication to help with symptoms_____ _____

YES	NO	
___	___	Anxiety and/or depression? Past or Present_____
___	___	Tobacco use within the last 24months_____
___	___	Alcohol use. How much daily/weekly_____

YES NO

___ ___ Caffeine intake (Coffee, tea, soda, chocolate, etc.) How much daily?_____
___ ___ New glasses. If so, when was last eye exam? _____
___ ___ High or low blood pressure? If yes, is this presently being managed?_____
___ ___ Heart disease_____
___ ___ Seizure_____
___ ___ Memory loss_____
___ ___ Difficulty swallowing _____
___ ___ Difficulty walking or slurred speech_____
___ ___ Weakness of arms or legs_____
___ ___ Numbness or tingling of the face or extremities _____
___ ___ Body pain. Where & when did symptoms start?_____
___ ___ Cancer. What type & when?_____
___ ___ Eye problems (other than glasses) What?_____
___ ___ What sort of work do you do/or used to do?_____
___ ___ Family history of dizziness, balance, or hearing symptoms? Explain_____
_____
___ ___ Other:_____

VII. Previous Studies

YES NO

___ ___ Ear tests (hearing , ABR, VNG, etc.)_____
___ ___ Neurological tests (EEG, cerebral angiogram, carotid Doppler, etc.)_____
___ ___ General medical tests (blood tests, EKG, tilt table, etc.)_____
___ ___ Scans (x-ray, MRI, CT, etc.)_____

VIII. Medications

Please list your current medication and why they are taken.

Medications	Condition that medication is treating	Length of time on medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which medication have you taken in the past 48 hours (prior to VNG testing)?

_____

_____

_____

VISION

When was the last time you had your vision checked? _____

Do you have a vision problem? Yes / No

Do you wear corrective lenses or glasses? Yes / No

Do you have an Ocular Prosthesis? Yes / No

Do you have Congenital Nystagmus? Yes / No

Do you have Macular Degeneration? Yes / No