

ENG/ VNG (Electronystagmography/ Videonystagmography)

Patient Instructions

You are instructed to refrain from taking certain medications for 48 hours prior to your test date. Certain medications/substances can influence the body's response to the test, thus giving a false or misleading result. You will find a short list below of medications/substances that will affect test results. If you have any questions or concerns about discontinuing medications please consult your doctor.

Alcohol: beer, wine, cough medicine

Anti-seizure medicine: Dilantin, Tegretol, Phenobarbital

Anti-vertigo medicine: Anti-vert, Ru-vert, Meclizine

Sedatives: Halcoin, Restoril, Nembutal, Seconal, Dalmane, or sleeping pills

Tranquilizers: Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanax

Analgesics- Narcotics: Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet

Anti- nausea medicine: Atarax, Dramamine, Compazine, Bucladin, Phenergan, Thorazine, Scopalominine, Transderman

Anti-histamine: Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin, any over the counter cold/allergy remedies

You may take blood pressure medications, heart medications, thyroid medication, Tylenol, insulin, estrogen, etc.

Always consult with your physician before discontinuing any prescribed medication.

Please eat lightly for 12 hours prior to your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon eat a light breakfast and have a light snack for lunch. ***Please avoid caffeine in beverages such as coffee or soft drinks.***

Do not wear eye makeup (mascara, eye shadow, etc..).

Please bring glasses/contact lenses to the appointment.

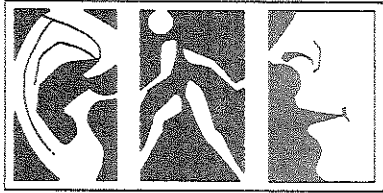
The Exam

A comprehensive battery of tests will be performed during the two hour appointment allocated for you. Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment, however, if this is not possible try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

Once your evaluation is completed each part is carefully evaluated and reviewed. This process is as important as your test, so please understand that your test results will not be discussed in detail at the time of your evaluation. Once the interpretation has been made, a detailed report will be forwarded to your referring physician.

Please call **203-287-9915** if you have any questions about this exam.



C E N T E R

Patient Questionnaire

PATIENT NAME: _____ DATE: _____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not effect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

A. Do you experience any of the following sensations? Please read the entire list first. Then put an 'X' in either the 'Yes' or 'No' box to describe your feelings most accurately.

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience motion sickness, airsickness or seasickness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have motion sickness as a child? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a family history of motion sickness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer from migraine headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you exposed to any solvents, chemicals, etc.? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have any injuries to your head? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | If you received a head injury, were you unconscious? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever fallen? How many times? ____ Where? _____ Inside/Outside of the home? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you afraid of falling? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take any medications regularly? What? _____ |

B. If you have dizziness, please put an 'X' in either the 'Yes' or 'No' box and fill in the blank spaces. If you do not experience dizziness, please go to Section C.

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | My dizziness is constant? |
| <input type="checkbox"/> | <input type="checkbox"/> | If in attacks, how often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you completely free of dizziness between attacks? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any warning signs that the attack is about to start? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the dizziness provoked by head/body movements? If so, which direction? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the dizziness better or worse at any particular time of the day? If so, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will stop your dizziness or make it better? What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything make your dizziness worse? What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of any possible causes of your dizziness? What? _____ |

****TURN OVER****

C. Do you experience any of the following sensations? Please read the entire list first then please put an 'X' in either the 'Yes' or 'No' box to describe your feelings most accurately.

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Light headedness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Swimming sensation in the head? |
| <input type="checkbox"/> | <input type="checkbox"/> | Blacking out or loss of consciousness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects spinning or turning around you? |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensation that you are turning or spinning inside, with outside objects remaining stationary? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall? Which direction? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you veer to the right? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you veer to the left? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have trouble walking in the dark? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have problems turning to one side or the other? |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting? |
| <input type="checkbox"/> | <input type="checkbox"/> | Pressure in the head? |

D. Have you ever experienced any of the following symptoms? Please put an 'X' in either the 'Yes' or 'No' box accordingly and circle if Constant or if in Episodes.

- | | | | |
|--------------------------|--------------------------|-------------------------------------|------------------------|
| YES | NO | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Double Vision? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision or blindness? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots before your eyes? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness of face, arms, or legs? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion or loss of consciousness? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in swallowing? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling around the mouth? | Constant Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty speaking? | Constant Episodes |

E. Do you have any of the following symptoms? Please put an 'X' in either the 'Yes' or 'No' box accordingly and circle the ear involved.

- | | | | | | |
|--------------------------|--------------------------|---|----------------------------|------------------|-----------------|
| YES | NO | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty hearing? _____ | Both Ears | Right Ear | Left Ear |
| | | When did this start? _____ | Is it getting worse? _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the hearing change with your symptoms? | | | |
| | | If so, how? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Noise in the ears? _____ | Both Ears | Right Ear | Left Ear |
| | | Describe the noise? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the noise change with your symptoms? | | | |
| | | If so how? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything stop the noise or make it better? If so what? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fullness or stuffiness in your ears? | Both Ears | Right Ear | Left Ear |
| <input type="checkbox"/> | <input type="checkbox"/> | Does this change when you are dizzy? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in your ears? | Both Ears | Right Ear | Left Ear |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from your ears? | Both Ears | Right Ear | Left Ear |

* Reference The American Institute of Balance patient questionnaire *