



Las Vegas, NV - 3120 S. Rainbow Blvd, Ste 202 -702.233.4327
Las Vegas, NV - 6475 N. Decatur Blvd, Ste 125 - 702.933.9103
Las Vegas, NV - 9430 W. Lake Mead Blvd, Ste 11 - 702.527.6066
Henderson, NV – 2642 W. Horizon Ridge, Ste A11 – 702.933.9102

Electronstagnomography (ENG)/Videonystagnomography (VNG)

An ENG or VNG has been ordered by your physician to help determine the cause of your dizziness or balance problem. The procedure is painless, and will last 60 to 90 minutes. During the test, eye movements will be recorded while you follow lights and lay in different positions, and while warm and cool air are introduced into each ear canal. Recordings will either be made with electrodes, which are placed on the face with tape (ENG), or by infrared goggles (VNG).

You have been scheduled for an ENG/VNG on _____ at _____. The test requires about sixty to ninety (60-90) minutes to complete. Although some people experience some dizziness during the test, the dizziness is of short duration, and by the completion of the test, all dizziness should subside. 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 you 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 you and/or your referring physician.

Patient Instructions

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

Antidepressants: Zoloft, Lexapro, Cymbalta, Paxil, Prozac, Elavil, Wellbutrin. **Alcohol:** Beer, Wine, Cough Medicine. **Analgesic-Narcotics:** Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet. **Anti-histamines:** Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Traiminic, Hismanol, Claritin..any over the counter cold remedies. **Anti-seizure Medication:** Dilantin, Tegretol, Phenobarbital. **Anti-vertigo Medication:** Anti-vert, Ru-vert, Meclizine. **Anti-nausea Medication:** Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal. **Sedatives:** Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill. **Tranquilizers:** Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranzene, Xanax.

**You make take blood pressure medication, heart medication, thyroid medication, Tylenol, insulin, estrogen, etc. Always consult with your physician before discontinuing any prescribed medications.

Note: Medications can be resumed immediately following the VNG testing procedures. **If there are any questions about the test or medication, please contact your doctor our offices.**

Please eat lightly for the 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.**

PLEASE DO NOT WEAR EYE MAKEUP (MASCARA, EYE SHADOW, ETC.)

Your cooperation in the following these instructions will improve the quality of your evaluation.

PLEASE BRING THE COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT

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

The following questions refer to your feeling of dizziness and/or imbalance. 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”:

When did you first notice the feeling of dizziness and/or imbalance and approximately how long did it last?

1) Do you ever have any of the following sensations? (check all that apply)

- Spinning in circles
- World spinning around you
- Falling to one side
- Imbalance

2) The following refer to a typical dizzy spell (check all that apply):

- Are you dizzy or unsteady constantly?
- Do the dizzy spells come in attacks?
How often? _____
How long? _____
Date of first spell? _____

- Are you free from dizziness between attacks?
- Does your hearing change with an attack?
- Are you dizzy mainly when you sit or stand up quickly?
- Are you more dizzy in certain positions?
Which positions? _____
- Are you nauseated during an attack?
- Have you had a recent cold or flu preceding recent dizzy spells?
- Have you had trouble walking in the dark?
- Are you better if you sit or lie perfectly still?
- Is there anything that you have found that makes your dizziness worse?
If yes, explain: _____
- Is there anything that you have found that helps your dizziness?
If yes, explain: _____
- Do you black out or faint when dizzy?
- Do you feel lightheaded or have a swimming sensation when you are dizzy?
- Do you find yourself breathing faster or deeper when excited or dizzy?

3) Is your dizziness or imbalance brought on by (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Standing up | <input type="checkbox"/> Rapid head movements |
| <input type="checkbox"/> Walking on uneven surfaces | <input type="checkbox"/> Bending over | <input type="checkbox"/> Loud noises |
| <input type="checkbox"/> Coughing, sneezing or straining | <input type="checkbox"/> Movement of objects | <input type="checkbox"/> Menstrual periods |
| <input type="checkbox"/> Moving your eyes when head is still | (if applicable) | |

4) The following refer to other sensations you may have (check all that apply):

Have you had:

- | | |
|---|---|
| <input type="checkbox"/> Severe or recurrent headaches | <input type="checkbox"/> Jerking of arms or legs |
| <input type="checkbox"/> Double or blurry vision | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Weakness or clumsiness in arms or legs | <input type="checkbox"/> Confusion or memory loss |
| <input type="checkbox"/> Spots before your eyes | <input type="checkbox"/> Motion sickness |
| <input type="checkbox"/> Recent head trauma (if yes, explain) | |

5) 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 hearing loss? | Yes | No | | |

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

- Is your dizziness related to:
- | | | |
|---|-----|----|
| Moments of stress?..... | Yes | No |
| Overwork or exertion?..... | 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 alcohol? | Yes | No |
| How much? _____ | | |
| Do you smoke?..... | Yes | No |



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Past Medical History:

Please list your current medical problems and length of illness:

Please list all surgery performed and approximate dates:

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
- Migraines?..... Yes No

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

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