PROFESSIONAL HEARING MANAGEMENT, INC.
2601 BEECH STREET
VALPARAISO, IN 46383

Nancy Dickey, Au.D.
Doctor of Audiology

Office (219) 464-9580
Fax (219) 464-0640

VNG TESTING

The VNG (Videonystagmography) is a diagnostic test performed on patients presenting symptoms of vertigo, dizziness, unsteadiness, lightheadedness, poor equilibrium, etc.

The VNG test utilizes a recording of nystagmus (an involuntary eye movement directly related to a nerve connection from the inner ear) to diagnose whether the patient has a normal vestibular mechanism, disease of one or the other labyrinthine organs, or central nervous system disease.

The VNG test includes: Tracking moving objects with the eyes (gaze nystagmus testing, optokinetic nystagmus, sinusoidal tracking), testing the effect of various positions of the body on the balance center and stimulation of each inner ear individually using cool and warm air.

The VNG test is an important part of a battery of diagnostic tests used to aid in the diagnosis of the cause of each patient's dizziness.

AUDIOGRAM: Measures hearing sensitivity for tone and speech stimuli.

Your appointment is_____at_____.
Allow 1 to 2 hours for your testing.

It is essential that you bring your insurance information with you at your appointment so that we may bill your insurance company upon completion of your testing. <u>We request 48 hours for cancellation of appointment.</u>

Certain medications may change the findings of the tests. If you take any medication routinely, please advise our office of the name and dosage prior to your appointment. We ask that you **NOT TAKE OF THE FOLLOWING TYPES OF MEDICATIONS FOR A PERIOD OF 24 HOURS PRIOR** to the appointment time.

Anti-dizzy pills	Anti-seizure medications
Pain medications	Narcotics of any kind
Tranquilizers	Sleeping Pills
Cold or allergy medications	Antihistamines
Alcoholic beverages	Caffeinated coffee, tea, cola, and chocolate

<u>Refrain from eating, drinking, and smoking for at least 6 hours prior to the time of the VNG</u>. (Diabetics should bring a light snack.) **Do not wear contacts lenses, earrings/jewelry or use lotions, foundation, powder, eyeliner or mascara makeup on your face.** Video goggles are used during testing and makeup distorts the results. We suggest that if possible, you wear slip-on shoes and comfortable clothing. We also suggest that you bring someone with you to drive you home as you may experience some dizziness during the test.

NOTE: Be sure to bring the attached questionnaire when you come for the VNG.

(1/13)

Office Use Only
NPO 6H: Y or N
Meds 24H: Y or N

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DIZZINESS QUESTIONNAIRE

Pt. Name_____Age:_____Date of VNG_____

If you are having a problem with your balance or with dizziness, please answer the following questions:

1. Describe your imbalance? **(Start date, body position, recurrences)**

   _____

   _____

   _____

2. What does it feel like? _____

   _____

3. Is dizziness constant? _____yes_____no In episodes?_____yes_____no
4. How long does it last? ___Seconds ___Minutes ___Hours ___Days
5. How often (on average) does it recur?_____
6. When was your most recent episode?_____
7. Do you ever have a spinning sensation or a sense of motion? _____yes _____no
8. Do you have hearing loss? _____yes_____no Which ear? R___ L___ Both___
9. Does your hearing worsen with these episodes? _____yes _____no
10. Do you have any noise in your ears? _____yes_____no Is it constant? __yes__no

    If yes, does the noise change with dizziness? ___yes____no how?_____
11. Have you lost consciousness with the attacks? _____yes _____no
12. Do you have fullness/stuffiness in your ears?

    _____no _____both ears _____right _____left
13. Do you have a history of migraine headaches? ___yes ___no

    If yes, give details (onset, frequency, other symptoms, medication)_____

    _____
14. Have you ever injured your head? _____yes _____no

    If yes, when and how?_____
15. Were dizzy spells preceded by any headache, flu, upper respiratory infection? _____yes _____no

16. Were dizzy spells preceded by any underwater diving or airplane travel? _____yes _____no

17. Were dizzy spells preceded by any heavy lifting or ear infection? _____yes _____no

18. Have you become nauseated when "dizzy"? ____yes ____no
Have you vomited? ____yes _____no

19. Do you become "dizzy" when you are in any certain positions, or when you are moving from one position to another? _____yes _____no
If yes, which positions?_____

20. Have you ever been treated for this problem before? _____yes _____no
If yes, where/when/diagnosis_____

21. Do you have any problems with your eyes or with your vision? _____yes _____no
If yes, please describe:_____

22. Do you know of any possible causes for your dizziness? _____yes _____no
If so, please describe:_____
_____

23. Do you know of anything that will stop your dizziness or make it better?
_____yes _____no
If yes, please describe:_____
_____

24. Do you know of anything that will make your dizziness worse? _____yes _____no
If yes, please describe:_____
_____

25. Do you take any medications? _____yes _____no
List all medications:_____
_____

26. Have you taken any medications within 24 hours of your testing today? If yes, which ones?_____
_____