VNG PATIENT INSTRUCTIONS

PATIENT INSTRUCTIONS:

1. **DO NOT TAKE** the following medications for 48 hours prior to your evaluation. These medications can influence the body's response to the test, thus providing false or misleading results. If you have any questions or concerns about discontinuing any of the following, please do not hesitate to contact your doctor:
   Alcohol: beer, wine, cough medications
   Analgesics/Narcotics: Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet
   Anti-histamines: Clor-trimeton, Dinetapp, Disphrol, Benadryl, Actified, Teldin, Triaminic, Hismanol, Claritin, Zyrtec, Xyzal, or any over the counter cold remedies.
   Anti-seizure medicine: Consult with your doctor
   Anti-vertigo medicine: Antivert, Ru-Vert, Meclizine
   Anti-nausea medications: Atarax, Dramanine, Compazine, Antivert, Bucladin, Phenergan, Scopalomine, Transdermal patches
   Caffeine products: Coffee, Tea, Soft drinks
   Sedatives: Restoril, Nembutal, Seconal, Delamine or any sleeping pills
   Tranquilizers: Valium, Atarax, Serax, Ativan, Traxene, Xanax

2. **YOU MAY TAKE**: Blood pressure medications, heart medications, thyroid medications, Tylenol, insulin, estrogen, etc. Always consult with your doctor before discontinuing any prescribed medications.

3. **Please eat lightly** for 12 hours prior to your appointment. If your appointment is in the morning, you may have a light breakfast. Please avoid caffeine products prior to testing.

4. **Please do not wear eye make-up, mascara, eye shadow, liner, etc.**

5. **Please wear comfortable clothing.**

6. **If possible, we encourage you to have someone drive you to and from your appointment.** Once test is completed, a report with interpretations and recommendations will be compiled. Please schedule at your convenience a follow-up appointment with your referring doctor to review these evaluation results.

VNG QUESTIONNAIRE

Please complete this questionnaire and bring to your appointment.

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 to the best of your ability, but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur?_____

How long did it last?_____

Section 1

Do you experience any of the following sensations? Please read the entire list first. Put an "X" in either the first space for YES or the second space for NO to describe your feelings most accurately.

YES NO

( ) ( ) Do you experience motion sickness, airsick or seasick?

( ) ( ) Did you have motion sickness as a child?

( ) ( ) Do you have a family history of motion sickness?
Parent _____ Sibling _____ Child_____

( ) ( ) Do you have migraine headaches?

( ) ( ) Were you exposed to solvents, chemicals, etc.?

( ) ( ) Did you have any injuries to your head? When _____

( ) ( ) If you received a head injury, were you unconscious?

( ) ( ) Have you ever had a neck injury?

( ) ( ) Have you ever fallen? How many times _____ Where _____

( ) ( ) Are you afraid of falling?

( ) ( ) Do you take any medication regularly? If so, please list (or attach a list):
_____

( ) ( ) Do you use alcohol?

Section 2

If you have dizziness, please check with YES or NO and fill in the blank spaces. If you DO NOT experience dizziness, please go to Section 3.

YES NO

( ) ( ) Is your dizziness constant? If you answer yes, please go to Section 3.

( ) ( ) If attacks, how often? _____

( ) ( ) Are you completely free of dizziness between attacks?

( ) ( ) Do you have any warning that the attack is about to start?

( ) ( ) Is the dizziness provoked by head or body movements?
Which direction _____

( ) ( ) Is the dizziness better or worse at any particular time of the day?
When _____

( ) ( ) Do you know of anything that will stop your dizziness or make it better?
What _____

( ) ( ) Does anything make it worse?
What? _____

( ) ( ) Does anything accelerate an attack?
What? _____

( ) ( ) Do you know any possible cause of your dizziness?
What? _____

Section 3

Do you experience any of the following sensations? Please read the entire list then mark an "X" in the space for either YES or NO to describe your feelings most accurately.

YES NO

( ) ( ) Light Headedness?

( ) ( ) Swimming sensation in the head?

( ) ( ) Blacking out or loss of consciousness?

( ) ( ) Objects spinning or turning around you?
( ) ( ) Sensation that you are turning or spinning inside, with outside objects remaining stationary?

( ) ( ) Tendency to fall? If yes, please answer the questions in Section 4.
Right_____ Left_____ Forward_____ Backward_____

( ) ( ) Loss of balance when walking? Veering to the Right___ Veering to the Left___

( ) ( ) Do you have trouble walking in the dark?

( ) ( ) Do you have problems turning to one side or the other?

( ) ( ) Nausea or vomiting?

( ) ( ) Pressure in the head?

SECTION 4

Have you ever experienced any of the following symptoms? Place an "X" in the space for either YES or NO and circle if CONSTANT or IN EPISODES.

YES NO

( )	( )	Double vision?	Constant	In Episodes
( )	( )	Blurred vision?	Constant	In Episodes
( )	( )	Spots before your eyes?	Constant	In Episodes
( )	( )	Numbness of face, arms or legs?	Constant	In Episodes
( )	( )	Weakness in arms or legs?	Constant	In Episodes
( )	( )	Confusion?	Constant	In Episodes