Pacific Hearing & Balance, INC.

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Balance Testing/Therapy
Hearing Aids
Children and Adults

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I have received the instructions and questionnaire packet for the Videonystagmography (VNG) and Rotational Chair Examination.

_____
Patient initials

I agree to read the instructions at least 3 days prior to my scheduled exam and follow all instructions, i.e.: food, medications and makeup.

_____
Patient initials

I understand that not complying with the instructions may result in rescheduling my appointment.

_____
Patient initials

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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Head and Neck Surgery
Ear, Nose & Throat
Adults and Children

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Adults and Children

Howard R. Krauss MD
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Neuro-Ophthalmology
Orbital & Strabismus Surgery
Cataract & Laser Vision Correction
Oculoplastic Surgery

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West Wilshire Medical
Surgical Center, LTD, INC

You have been scheduled for a Videonystagmography, (VNG), and Rotation Test. This is a battery of tests to determine the cause of your dizziness. A VNG and rotational test assesses balance and movement disorders. It examines your vestibular system which is the portion of your inner ear responsible for balance function. Since you suffer from dizziness or balance problems, your vestibular system needs to be tested to see if it is working properly.

The entire test is based on examining eye movements, particularly a type of movement called nystagmus. These movements consist of a drift of both eyes in the same direction followed by a rapid movement in the opposite direction. Nystagmus occurs when your brain attempts to determine the position of your body when it receives conflicting messages from your ears. Nystagmus lets the examiner know the position you are in makes you dizzy. However, nystagmus is not always position-related, and not all causes of dizziness will create nystagmus.

The VNG/Rotation has four main parts:

First, you will watch steady and moving dots on a wall, providing information about how your eyes and brain work together.

Second, you will sit in a chair, which will rotate slowly from side to side. This stimulates your inner ears, and may make you dizzy. This is a normal response. Since you are in a controlled environment, there is no need to worry about falling. This test is not painful, and there is no need to be anxious. The results will be compared for both ears in order to determine if each ear is responding the same.

Third, you will move your head and body into different positions, to help determine which positions, if any make you dizzy.

Finally, you will undergo a caloric's test. Air or water of different temperatures will be cycled through your ear. This stimulates your inner ears, and may make you dizzy. This is a normal response that lasts only a few minutes. Since you are in a controlled environment, there is no need to worry about falling. The test is not painful, and there is no need to be anxious. The nystagmus results will be compared for both ears in order to determine if each ear is responding the same.

There is no need to fear this test. Some people are anxious because it may provoke dizziness. However, it is painless and in a professionally controlled environment. You will not fall, and your dizziness should subside quickly. You will be informed of each portion of the test as it happens.

If you have any questions regarding the test, please contact our office.

Please Read All Instructions Carefully:

1. Stop all medications for dizziness at least 3 days prior to the test. DO NOT STOP taking medications for **HIGH BLOOD PRESSURE**, **SEIZURES**, **DIABETES**, or other disorders. If unsure, consult your physician.

2. No alcohol in any amount 24 hours before testing (including wine, beer, & cough medicines containing alcohol).

3. No food or caffeinated beverages after midnight the night before the test. You will not be put to sleep, but you will be more comfortable during the test with an empty stomach. When a test is scheduled in the afternoon, no food or caffeinated beverages for 4 hours before the test.

4. No Anti-nausea medicine (Dramamine, Compazine, Bonine, Marezine, Vontrol, Phenergan, Thorazine, etc.).

5. No Antivertigo medicines (Antivert, Ru-vert, Dramamine, etc.).

6. No Narcotics or Barbituates (Phenobarbital, Codeine, Demerol, Dilaudid, Percodan, Phenaphen, etc.).

7. No antihistamines (Chior-Trimeton, Dimetane, Disophrol, Benadryl, Actifed, Teidrin, Thianimic, any over-the-counter cold remedies, etc.).

8. Do not wear make-up or apply oils or lotions to your face the day of the evaluation. This is important for assessing eye movements correctly.

9. Wear comfortable clothing.

10. Do wear your glasses — no contacts.

11. Bring someone with you to drive you home. A few people may continue to feel a little dizzy after the testing. Most people, however, feel fine after a few minutes.

12. Arrive on time or reschedule your appointment if necessary. Because this test takes 2 hours, a late or absent person greatly affects our schedule.

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Howard R. Krauss MD • Jeremy E. Levenson MD • Olivia Doyle PA-C

Patient Name _____ Date _____ Date of Birth _____

Hearing Section

Check all of the following that apply to you:

☐ I think I have a hearing loss, but this is not confirmed by testing

☐ I have a documented hearing loss
☐ In both ears
☐ Only in the right ear
☐ Only in the left ear

☐ My hearing changes from day to day

☐ I have a ringing or noise, (tinnitus), that I hear:
☐ In both ears
☐ Only in the right ear
☐ Only in the left ear
☐ Constant
☐ Intermittent

☐ I have a feeling of fullness or pressure in my ear(s)
☐ In both ears
☐ Only in the right ear
☐ Only in the left ear
☐ Constant
☐ Intermittent

☐ I have pain in my ear(s)
☐ In both ears
☐ Only in the right ear
☐ Only in the left ear
☐ Constant
☐ Intermittent

Do you have dizziness?
☐ No
☐ Yes
If yes, when did your dizziness first occur?
_____

Are your symptoms with you 24 hours per day? (Never stopping)
☐ No
☐ Yes

If yes, check all the symptoms that are present 24 hours per day never stopping:
☐ Off balance when standing or walking
☐ Off balance when sitting or lying
☐ Lighted headed or fainting sensation
☐ Tumbling or spinning sensation

Do you have symptoms that occur in spells?
☐ No
☐ Yes
If yes, check all symptoms that occur in spells, (no matter how long the spell):
☐ Off balance when standing or walking
☐ Off balance when sitting or lying
☐ Lighted headed or fainting sensation
☐ Tumbling or spinning sensation
Check the one, on average, that describes the length a typical, single, spell:
☐ Measured in seconds
☐ Measured in minutes to hours, but less than 24 hours
☐ Measured hours to days, but less than 7 days
☐ Measure in days, can last continuously for weeks
Check the one, on average, that describes how frequently your spells are occurring:
☐ Daily or Multiple times per day
☐ Multiple times per week
☐ Multiple times per month
☐ Several times in a 2-month interval
☐ Several times in a 6-month interval
☐ Several times in a 12-month interval

Do you ever have symptoms occur when you are sitting, standing, lying completely still, NOT having just moved and NOT watching anything that is moving?

☐ No
☐ Yes

If yes, check all the symptoms that occur in this spontaneous manner:

☐ Off balance
☐ Lighted headed or fainting sensation
☐ Tumbling or spinning sensation

Do you ever have symptoms that are provoked by you making a movement or change in position?

☐ No
☐ Yes

If yes, check all the symptoms that occur with your movement or position change:

☐ Off balance
☐ Lighted headed or fainting sensation
☐ Tumbling or spinning sensation

Are your symptoms made worse by any of the following? (check **all** that apply):

☐ Lying down/rolling in bed
☐ Walking in the dark
☐ Hot baths or showers
☐ Menstrual cycle
☐ Automobile rides
☐ Loud sounds
☐ Reading
☐ Exercise
☐ Lifting things
☐ Sitting up/standing up
☐ Walking on uneven surfaces
☐ Coughing/sneezing/nose blowing
☐ Windshield wipers
☐ Restaurants or movie theaters
☐ Turning your head when walking
☐ Overexertion
☐ Escalators

Associated Symptoms and Problems

Check all the following symptoms that you have experienced:

Symptom	In the past	With dizziness/imbalance
Unexplained falls	☐	☐
Sensation of being pulled or pushed	☐	☐
Sensation of swaying or rocking	☐	☐
Loss of consciousness (black out)	☐	☐
Nausea and/or vomiting	☐	☐
Double vision (side by side or up down)	☐	☐
Vision "jumps" when walking/riding	☐	☐
Cloudiness or blurred vision	☐	☐
Blindness	☐	☐
Heart racing/palpitations	☐	☐
Panic feeling/Anxiety	☐	☐
Numbness of face or extremities	☐	☐
Weakness or clumsiness in arms/legs	☐	☐
Difficulty with speech	☐	☐
Difficulty with swallowing	☐	☐

Headaches

Have you had a total of 5 or more headaches (does not matter how severe) in your lifetime?

☐ Yes
☐ No

Have you ever had a headache that was severe enough to make you stop your activity and sit or lie down?

☐ Yes
☐ No

Have you ever experienced a temporary change in vision, such as jagged lines, color spots or lightening bolts in your vision; loss of vision recovery?

☐ Yes
☐ No

If you answered YES to any of the three questions above complete the following section. If you answered NO to all, skip down to the section entitled "Other Disorders".

Please check all of the following that you have experienced:

- ☐ Headaches where the discomfort localizes to a region(s) of the head
- ☐ Increased sensitivity to light during a headache
- ☐ Increased sensitivity to sound during a headache
- ☐ Increased sensitivity to odors during a headache
- ☐ A headache provoked by sudden bright light, such as sunlight
- ☐ Increased chance of headache around your menses (N/A ☐)
- ☐ Change in headache behavior with pregnancy or after (N/A☐)
- ☐ Certain foods or beverages increase the chances of a headache
- ☐ Motion sickness as a young child prior to puberty
- ☐ Nausea and/or vomiting with a headache
- ☐ Headache that lasted longer than 24 hours
- ☐ Headache associated with your problems of dizziness/imbalance
- ☐ Headache where the pain throbs or pulses

If having headaches, at what age do you first remember having a headache?

Under age 12

- ☐ In your teens
- ☐ In your twenties or thirties
- ☐ In your forties or fifties
- ☐ In your sixties or seventies
- ☐ In you eighties

Other Disorders

Do you currently have or have you been diagnosed in the past with any of the following? Please check all that apply:

- ☐ Stroke
- ☐ Heart problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Cataracts
- ☐ Joint disease
- ☐ Sexual dysfunction
- ☐ Seizures
- ☐ Loss of taste
- ☐ Loss or smell
- ☐ Brain or Spinal cord disorder
- ☐ High blood pressure
- ☐ Anxiety/depression/panic
- ☐ Glaucoma
- ☐ Ongoing breathing problems
- ☐ Blood disease
- ☐ Memory problems
- ☐ Ongoing numbness or tingling
- ☐ Ongoing stomach problems
- ☐ Significant weight changes

Hospitalizations and Injuries

Have you been in the hospital for any of the following or had any of the following injuries? Please check all that apply:

- ☐ Hospitalized for treatment of an infection with antibiotic therapy
- ☐ Surgery on either ear
- ☐ Surgery on either eye
- ☐ Eye injury
- ☐ Ear injury
- ☐ Surgery on brain or spinal cord
- ☐ Surgery on hips/knees/ankles
- ☐ Head or neck injury
- ☐ Broken back/hip/knee/ankle

Other Medical History

Please indicate what tests you have had for your problem. Check all that apply:

Test	Normal	Abnormal	Don't know
Hearing test (audiogram)	☐	☐	☐
MRI of brain with injection	☐	☐	☐
MRI of brain without injection	☐	☐	☐
MRI of neck or back	☐	☐	☐
ENG (water or air in the ear test)	☐	☐	☐
Electrocochleography (EcoG)	☐	☐	☐
EEG (brain wave test)	☐	☐	☐
Auditory brainstem test (ABR)	☐	☐	☐
Tilt table test (for fainting)	☐	☐	☐

Rotational chair for dizziness	☐	☐	☐
Spinal tap (lumbar puncture)	☐	☐	☐
Posturography (standing balance test)	☐	☐	☐
Doppler/Ultrasound blood flow test	☐	☐	☐
MRA of head and neck blood flow	☐	☐	☐
Blood test for syphilis	☐	☐	☐
Blood test for Lyme disease	☐	☐	☐
Blood test for thyroid function	☐	☐	☐
Blood test for CBC, electrolytes	☐	☐	☐

Social and Family History

Please check all that apply to you:

- ☐ Smoke
- ☐ Drink caffeinated beverages
- ☐ Alcohol
- ☐ Repeated direct exposure to loud noises
- ☐ Repeated exposure to toxic items
- ☐ History of "Recreational Drug" use

Check all that apply to anyone in your family:

- ☐ Dizziness
- ☐ Diabetes
- ☐ Hearing loss
- ☐ Imbalance and /or falling
- ☐ Heat disease
- ☐ High blood pressure
- ☐ Headaches
- ☐ Stroke
- ☐ Anxiety

Medications

Please list or attach a list of all your current medications, over the counter drugs, and medications you have tried in the past for your problem:

Name of the Medication	Used for Treatment of:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please bring this document to your appointment. This information is pertinent in the diagnosis of the medical problem for which you are seeking treatment.