PREP INSTRUCTIONS FOR PATIENTS
ENG/VNG

ENG (electronystagmography)
VNG (Videonystagmography)

Your ears must be cleared of cerumen (wax). If you have a problem with wax, please have it removed before your test.

PLEASE ARRIVE ON AN EMPTY STOMACH, (AT LEAST 4 HOURS PRIOR TO TESTING). IF YOU NEED TO EAR FOR MEDICAL REASONS LIKE DIABETES, PLEASE HAVE A LIGHT MEAL

Bring with you: **prescribed eyeglasses or contacts.**

Remove all eye make-up prior to your test.

For **72 hours** before the test **avoid** the following medications (**if you're unsure check with your physician before stopping) : Barbiturates, Anticonvulsants, Tranquilizers, Antihistamines and cold/allergy medications, narcotics.**

No antivert or meclazine for 72 hours before your test.

No alcohol or smoking

If you have any questions please call
TESTING IN MEADVILLE: 814.333.5100
TESTING IN GROVE CITY: 724.458.0511 OR CALL DR WHITE @ 814.373.3070

PLEASE DO NOT BRING CHILDREN WITH YOU TO THIS APPOINTMENT AS IT TAKES APPROXIMATELY 90 MINUTES FOR THIS TEST.

THANK YOU.

Audiology Department

Date________________________ Married/Single/Divorced (Circle One)

Patient' Social Security Number______________________

Patient's **Full** Name ______________________________

Date of Birth _____________ Patient's age today ______________

Patient's other name oRMaiden Name ____

Patient's **Full** Address ____

Patient's Phone Number ______________________ County or Township ____________

Patient's Next of Kin/Family Contact ____

Contact Address and phone number ____

Patient's Family Doctor __________________ Who is referring Doctor ______________

Phone number of family doctor (if not local) _____________________________________

Patient's Employer ____

Employer's Full address and phone ____

Patient's occupation _________________________ Full time or Part time ____________

(PLEASE PROVIDE YOUR INSURANCE CARDS FOR COPYING PURPOSES)

Name of Insurance ____

Policy Holders name ____

Policy holders Employer ____

Have you ever had your hearing tested before? _______ Where and When ______________

When did you first notice or suspect a hearing problem? ____________________________

Has your hearing decreased gradually or is was it sudden ___________________________

Explain, if necessary - ____

Do you feel you hear better in one ear over the other? (left or right) __________________

Have you ever had ear surgery? _____________ When and Where_________________

Do you have buzzing or ringing in you ears? _______ Describe: ____________________

Do any members of your family have hearing problems? _____________________________

Have you ever worked in a noisy job? _____ How long? _____ Where? _____________

Have you EVER	In previous 90 days, ONLY	Past or Present
__ been in military	__dizziness	__ high blood pressure
__ played in band	__ lightheadedness	__ scarlet fever
__ hunted	__ loss of balance	__ measles/mumps
__ used pistols	__ room spinning	__ head injury
__ used rifles	__ ear aches/pain	__ multiple sclerosis
__ used shotguns	__ fluctuating hearing	__ arteriosclerosis
__ used chainsaws	__ ear infections	__ diabetes
__ used farm machinery	__ ear drainage	__ meningitis
__ full/plugged ears	__ allergy problems	
__ Meniere's Disease		

NAME ______________________

Portion of the Dizziness Questionnaire Relating to the Definition of Symptoms.

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When you are dizzy do you experience any of the following sensations? Please read the entire list first. Then circle Yes or No to describe your feelings most accurately.

YES	NO	Lightheadedness
YES	NO	Swimming sensation in the head
YES	NO	Blacking out
YES	NO	Loss of consciousness
YES	NO	Tendency to fall: To the right?
YES	NO	To the left?
YES	NO	Forward?
YES	NO	Backward?
YES	NO	Sensation of being thrown toward ceiling or floor
YES	NO	Objects spinning or turning around you
YES	NO	Sensation that you are turning or spinning inside, with outside objects remaining stationary

Loss of balance when walking:

YES	NO	Veering to the right
YES	NO	Veering to the left
YES	NO	Headache
YES	NO	Nausea or vomiting
YES	NO	Pressure in the head

Portion of the Dizziness Questionnaire Investigating Associated Symptoms that May Be Suggestive of Neurological Disease.

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Have you experienced any of the following symptoms? Please circle Yes or No and circle if Constant or if in Episodes.

YES	NO	Double vision	Constant	In episodes
YES	NO	Numbness of face or extremities	Constant	In episodes

YES	NO	Blurred vision or blindness	Constant	In episodes
YES	NO	Weakness in arms or legs	Constant	In episodes
YES	NO	Clumsiness in arms or legs	Constant	In episodes
YES	NO	Confusion or loss of consciousness	Constant	In episodes
YES	NO	Difficulty with speech	Constant	In episodes
YES	NO	Difficulty with swallowing	Constant	In episodes

Portion of Dizziness Questionnaire Relating to the Determination of Characteristics and Etiology of the Disorder.
****
Please circle Yes or No and fill in the blank spaces.

My dizziness is:

YES NO Constant?

YES NO In attacks?

When did dizziness first occur? ____________________

If in attacks:

How often? ________________________

How long do they last? __________

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

YES NO Are you completely free of dizziness between attacks?

YES NO Does change of position make you dizzy?

YES NO Do you have trouble walking in the dark?

YES NO When you are dizzy, must you support yourself when standing?

YES NO Do you know of any possible cause of your dizziness? If so, what? ____________________
____

Do you know of anything that will:

YES NO Stop your dizziness or make it better?

YES NO Make your dizziness worse?

YES NO Precipitate an attack?

YES	NO	Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?
YES	NO	Do you have any allergies?
YES	NO	Did you ever injure your head?
YES	NO	Were you unconscious?
YES	NO	Do you take any medications regularly? If so, what?________________
YES	NO	Do you use tobacco in any form? If so, how much?__

Portion of the Dizziness Questionnaire which evaluates Possible Associated Auditory Symptoms
****
Do you have any of the following symptoms? Circle Yes or No and circle the ear involved.

YES	NO	Difficulty in hearing?	LEFT/RIGHT/BOTH EARS
YES	NO	Noise in your ears? Describe the noise.________________	LEFT/RIGHT/BOTH EARS
YES	NO	Does noise change with dizziness? If so, how?______	
YES	NO	Fullness or stuffiness in your ears?	LEFT/RIGHT/BOTH EARS
YES	NO	Does this change when you are dizzy?	LEFT/RIGHT/BOTH EARS
YES	NO	Pain in your ears?	LEFT/RIGHT/BOTH EARS
YES	NO	Discharge from your ears?	LEFT/RIGHT/BOTH EARS