ENG/VNG Evaluation
Instructions

Patient Name:

Medical Record #:

Appointment

Place:

Date:

Time:

Provider:

You have been scheduled for an ENG/VNG appointment in the Head and Neck Surgery Department in either Modesto or Stockton.

The ENG/VNG evaluation is a test of the vestibular (balance) system and will take approximately 2 hours. Since the evaluation is a test of the vestibular system, some people will experience some dizziness and/or nausea during and after the test. Therefore, please arrange for someone to drive you home. It is also recommended that you have little in your stomach at the time of the test as a full stomach enhances nausea.

You will be required to wear facial goggles during the evaluation, so please do not wear heavy creams or make up on your face or around your eyes. Please do not wear perfume, cologne or scented lotion. Wear comfortable clothing and flat heeled shoes. It is important for you to be well rested the day of the test.

For 48 hours prior to the test, please DO NOT take any of the following:

- Benzodiazepines including: Valium, Lorazepam, and Xanax
- Pain medication including aspirin and narcotics
- Antihistamines including: Benadryl, Zyrtec, Allegra, and Claritin
- Decongestants including: Phenylephrine, Pseudoephedrine, and Sudafed
- Sleeping pills
- Anti-dizziness medications including: Meclizine, Dramamine, Antivert, Bonine and Scopolamine
- Tranquelizers and Anti-anxiety medications
- Alcohol
- Recreational Drugs
- Caffeine-including chocolate, coffee, tea and soft drinks

Please do not discontinue medications that are not on this list.

If you have any questions about the requirements of the test or the test in general, please contact the Head and Neck Surgery/ Audiology Department.

Please answer the questionnaire (attached) prior to your VNG appointment and bring the questionnaire with you to your appointment. This will help us assess your dizziness.

ENG/VNG Evaluation

Dizziness Questionnaire

Patient Name:

Medical Record #:

1. Date dizziness began:_____
2. Events prior to dizziness: _____
3. Describe dizziness:_____
   _____
4. Is dizziness constant or come in attacks? _____
5. If constant, does it change? _____
6. If attacks, how often do they occur and how long do they last? _____
7. If attacks, do they come on suddenly or gradually? _____
8. If attacks come on gradually, how can you tell that an attack is coming? _____
9. Does anything make your dizziness worse? _____
10. Does anything make your dizziness better? _____
11. Are you completely free of dizziness or lightheadedness in between attacks? _____
12. Does your dizziness incapacitate you or can you go on with your normal daily routine? ____
    _____
13. Do you have nausea or vomiting with dizziness? _____
14. Do you fall when dizzy? _____ If so, do you fall to the left, right or straight down? _____
    _____
15. Does anyone in your family have dizziness? _____
16. What do you believe is causing your dizziness? _____
17. Have you taken medication for dizziness? _____

Hearing Loss: Yes No Right Left

1. Hearing test date: _____
2. Hearing loss: _____
   Stable Progressive Fluctuating
3. Do you know what caused your hearing loss? _____
4. Does your hearing change when you are dizzy? _____
5. Do you wear hearing aids? _____
6. Do you have a history for ear infection? _____
7. Do you have a history of ear surgery? _____

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Dizziness Questionnaire

8. Do you have ringing in the ears? _____
9. If so, does it change when you are dizzy?_____
10. Do you have fullness in the ears?_____
11. If so, does it change when you are dizzy?_____

Medical Considerations:

1. Have you had head trauma, skull fracture or been knocked unconscious? _____ If so, please describe: _____.
2. Have you ever had whiplash or neck injury? _____ If so, please describe: _____
   _____
3. Do you have an ocular implant? _____
4. Do you have a history of headaches? _____ If so, please describe:_____
   _____
5. Does anyone in your family have a history of headaches? _____If so, please describe:
   _____
6. What medications are you currently taking: _____
   _____
   _____

Have you had any substances within the past 48 hours that may affect this test? Please report if you have. The quality of your results will be affected by the following: Alcohol, Antihistamine, Sleeping Pills, Anti-dizziness medication, Tobacco, Recreational drugs, Decongestants, Anxiety medication, Seizure medication, Depression medication, Caffeine: including coffee, tea, chocolate, diet pills.

Signature:_____

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Modified Dizziness Handicap Inventory:

Patient Name:

Medical Record #:

Date:

P I	Yes	No	Does looking up increase your problem?
F3	Yes	No	Because of your problem, do you restrict your travel for business or recreation?
FS	Yes	No	Because of your problem, do you have difficulty getting into or out of bed?
F7	Yes	No	Because of your problem, do you have difficulty reading?
P I 1	Yes	No	Do quick head movements increase your problem?
F12	Yes	No	Because of your problem do you avoid heights?
PI3	Yes	No	Does turning over in bed increase your problem?
6	Yes	No	Because of your problem, is it difficult for you to go for a walk by yourself?
P I 7	Yes	No	Does walking down a sidewalk increase your problem?
F19	Yes	No	Because of your problem, is it difficult to walk around your house in the dark?
E20	Yes	No	Because of your problem, are you afraid to stay at home alone?
E23	Yes	No	Because of your problem, are you depressed?
P25	Yes	No	Does bending over increase your problem?

Dizziness Handicap Inventory, PSB Revised 3/8/00
Larger score = greater problem