CENTER OF THE OZARKS

Pediatric & Adult Otorhinolaryngology
Facial Plastic & Reconstructive Surgery
Rhinology & Sinus Surgery
Otolaryngic Allergy
Otology & Audiology
Head & Neck Oncologic Surgery
Laryngology & Bronchoesophagology

Physicians: Felicia L. Johnson, MD
Lance A. Manning, MD
Kevin W. Lollar, MD
Jared R. Spencer, MD
Physician Assistant: Natasha Farnam, PA-C
Audiology: Patti Crews, AuD, CCC-A
Mary O'Brien, AuD, CCC-A
Dana Alexander, CPOP

The Videonystagmography (VNG) examination is used primarily in the evaluation of dizziness and imbalance. It is a painless procedure requiring approximately 1 ½ hours. The first portion involves wearing goggles equipped with a camera to follow your eye movements. The last portion of the test involves putting both cool and warm air into your ear canals. This may cause some dizziness, which subsides in a few minutes.

The results of the VNG test will help indicate whether more tests are needed to rule out possible ear or nerve disorders. In order to get valid results from the test, it is necessary for you to **NOT** take any of the following medications or beverages for two days (48 hours) prior to the time of your appointment. If you have a question about a particular medication, please call and ask.

Do Not Take
Sleeping pills (Dalmane, Halcion)
Aspirin, Tylenol
Antihistamines
Cough medicine
Alcoholic beverages
Pain medication
Muscle relaxers
Anti-dizzy medicine (Meclizine, Antivert)
Anti-depressants (Xanax, Prozac, Zoloft, etc.)

Do Take
Heart medicine
Diabetes medicine
Thyroid medicine
Blood pressure medicine
Seizure medicine
Birth control pills
Any antibiotics
Diuretics

NO Cosmetics or eye makeup please.
NO Eating or liquids two (2) hours before the test.
NO Coffee or Caffeinated beverages four (4) hours before the test.
NO Smoking four (4) hours before the test.

You may not feel like driving following your testing. You will want to make arrangements for a driver to take you home if necessary.

Because the VNG test is lengthy, we ask that you inform us as soon as possible if you are unable to keep your appointment. You will return for a follow-up appointment on another day to discuss these test results with a physician.

Please fill out the enclosed forms with this letter and bring them with you to your appointment.
Thank you for your cooperation.

Ear, Nose and Throat Center of the Ozarks
6823 Isaac's Orchard Rd.
Springdale, AR 72762
(479) 750-2080

Dizziness Questionnaire

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Referring Physician: _____

Describe your symptoms without using the word dizzy or vertigo: _____

_____

_____

How long have symptoms been present? _____

Onset of symptoms occurred: Gradually Suddenly

Dizziness occurs: All the time (constant) Comes and goes (episodic)

If episodic, how often do symptoms occur? _____

How long does a typical episode last? Seconds Minutes Hours Days

Is an episode ever triggered by anything specific? Yes No

If yes, explain: _____

_____

_____

Do episodes ever occur when you are moving? Yes No

Do you have car/boat/airplane sickness? Yes No

Do episodes cause changes in your hearing, unusual ringing/roaring sounds or pressure in your head/ears? Yes No

If yes, please explain: _____

_____

Does motion or movement make symptoms worse? Yes No

If yes, explain which types of activities or movements: _____

_____

Do you become nauseated with symptoms? Yes No

If female, is your dizziness associated with your menstrual cycle? Yes No N/A

Have you ever blacked out or fainted while having an episode? Yes No

How many times? _____

Have you ever fallen? Yes No How often? _____

During an episode, do you have problems with speaking? Yes No

During an episode, have you ever experienced arm or leg weakness? Yes No

Do you have high blood pressure? Yes No

If yes, is it controlled by medication? _____

Do you have a history of the following?
Stroke Heart disease Heart Surgery

Have you ever had a severe head injury with a loss of consciousness or skull fracture? Yes No

If yes, please explain: _____

_____

When having an episode, which of the following best describes your symptoms:

Lightheadedness Unsteadiness (imbalance) Sensation of spinning/moving

Do you have problems walking on uneven surfaces? Yes No

Does darkness or closing your eyes seem to make your symptoms worse? Yes No

Do you have problems watching objects moving in your environment (train going by, traffic,

sunlight through trees)? Yes No

Does coughing, laughing, sneezing or straining seem to make symptoms appear, or make symptoms worse? Yes No

Do you have problems with symptoms while driving? Yes No

If so, explain: _____

HEADACHES

Do you have headaches? Yes No
If yes, how often: _____

Do you have a history of migraine headaches? Yes No
If yes, do they seem to be related or affect dizziness? Yes No

Does anyone in your family have a history of migraine headaches? Yes No

Do you have a change in your vision during episodes? Yes No
If yes, please explain: _____

Do you have a history of eye or vision problems (glasses, contact or eye diseases)? Yes No

Do you hear clicking or other sounds, when you move your eyes? Yes No

HEARING

Do you have any problems with your hearing? Yes No

If yes, is one ear better or worse than the other? Right Left Same

Does your hearing fluctuate? Yes No

Have you ever had ear surgery? Yes No

If yes, explain: _____

_____

Do you have ear pain? Right Left Both None

Do you have drainage from your ears other than wax? Right Left Both None

Do you have fullness or a plugged sensation in your ears? Right Left Both None

Do you have ringing or roaring in your ears? Right Left Both None

Ringing in ears is: Constant Periodic Like a heartbeat

Do loud noises seem to affect symptoms? Yes No

MEDICAL HISTORY

What type of testing have you had for dizziness? _____

_____

Please list any other health problems not mentioned: _____

_____

Please list any prior surgeries: _____

_____

Please list all current medications: _____

_____

Have you taken any medications for your dizziness? Yes No

If yes, what type and were they helpful? _____

Is there anything you would like to add that was not asked on this questionnaire? _____

_____