3730 South Pinnacle Hills Pkwy, Suite 1
Rogers, AR 72758
(479) 750-2080

6823 Isaac's Orchard Road
Springdale, AR 72762
(479) 750-2080

Patient's Name:_____

Balance Appt Date:_____**Arrival Time:**_____ **Location:**_____

Follow Up Appt Date: _____**Arrival Time:**_____ **Location:**_____

The Videonystagmography (VNG) examination is used in the evaluation of dizziness. It is a test requiring approximately 1 ½ hours. The results of the VNG test will help indicate whether more tests will need to be ordered or to rule out ear or nerve related disorders. You may not feel like driving following your testing, therefore you should make arrangements for a driver to take you home.

In order to get valid results from this test, it is necessary that you **DO NOT** to take any of the following medications/beverages for **two days (48 hours) prior to your appointment**, as they can interfere with test results.

If you have a question about a particular medication, please call and ask.
We are happy to answer any questions that you may have, prior to your balance assessment.

DO NOT TAKE
Sleeping pills (Dalmane,Halcion)
Cold medicine (Tylenol PM)
Antihistamines (Benadryl)
Cough medicine (Actifed)
Alcoholic beverages
Narcotic pain medication
Muscle relaxers
Anti-dizzy medicine (Meclizine, Antivert, Phenergan)
Anti-depressants (Xanax, Prozac, Zoloft, etc
Sedatives or Barbiturates (Codeine, Phenobarbital)

DO TAKE
Heart medicine
Diabetes medicine
Thyroid medicine
Blood pressure medicine
Seizure medicine
Birth control pills
Antibiotics
Diuretics (Lasix)

NO Cosmetics or eye make-up.
NO Eating or liquids two (2) hours before the test.
NO Smoking/Nicotine/Vaping for four (4) hours before the test.

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Dizziness & Balance Medical History Questionnaire

Name:_____

Date of Birth:_____Referring Physician:_____

Dizziness Questionnaire:
Describe your symptoms without using the word dizzy or vertigo:_____
_____
_____
When did your problem first start?_____
Was it associated with a particular event (i.e. head injury)?_____
_____

Was the onset: Gradual Sudden
Is your dizziness: All the time (constant) Comes & goes (episodic)
If episodic, how often do your symptoms occur:_____

How long does a typical episode last (Circle): Seconds Minutes Hours Days
Is an episode ever triggered by anything specific? Yes No
If yes, please explain: _____

Do your symptoms occur when changing positions ? Yes No
If yes, please explain:_____
Does anything ever make symptoms better?_____
_____
Have you taken any medications for your dizziness? Yes No
Was it helpful? Yes No
What type of medication was it? _____
Which of the following best describes your symptoms (Circle all that apply)?:

Lightheadedness	Unsteadiness	Sensation of spinning	Veering
Floating	Imbalance	Objects in environment moving	

Do episodes ever occur when you are moving (i.e. in car)? Yes No
If yes, please explain:_____
Do you have car/boat/airplane sickness? Yes No
Do you become nauseated with symptoms? Yes No
Have you ever blacked out or fainted during an episode? Yes No
If yes, how many times?_____
Have you ever lost consciousness during an episode? Yes No
Have you ever fallen? Yes No
If yes, how many times?_____
Is your dizziness associated with your menstrual cycle? Yes No N/A

What type of testing have you had for your dizziness (Circle all that apply)?:

CT MRI Hearing Evaluation Blood Work

Occupational Therapy Physical Therapy Tilt Table Test

Do you have problems walking on uneven surfaces? Yes No
Does darkness or closing eyes make symptoms worse? Yes No
Do you have problems watching objects move? Yes No
(i.e. train going by, traffic, sunlight through trees)

Do you having problems with symptoms while driving? Yes No
Does coughing, sneezing or straining cause symptoms? Yes No
During an episode, do you have problems with speaking? Yes No
During an episode, do you have arm or leg weakness? Yes No

Hearing Questionnaire:
Do episodes cause changes in your hearing? Yes No
Do your episodes cause unusual ringing/roaring? Yes No
Do you have pressure in your ears during an episode? Yes No
Do loud noises seem to affect symptoms? Yes No
Does your hearing fluctuate? Yes No
Have you ever had ear surgery? Yes No
Do you have any problems with your hearing? Yes No
If yes, which ear is better than the other? Right Left Same
Do you have ear pain? Right Left Both None
Do you have drainage from your ears (excluding earwax)? Right Left Both None
Do you have a fullness or plugged sensation in your ears? Right Left Both None
Do you have ringing or roaring in your ears? Right Left Both None
Describe the noise you hear in your ears/head: _____
_____

Headaches/Migraines:

Do you have headaches? Yes No

If yes, how often:_____

Do you have a history of migraine headaches? Yes No

If yes, how often:_____

If yes, do they seem to be related or effect dizziness? Yes No

Do you have a family history of migraine headaches? Yes No

Do you have a history of seizures? Yes No

Vision:

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? Yes No

Have you ever had eye surgery? Yes No

If yes, what type of eye surgery?_____

_____

Do you hear clicking when you move your eyes? Yes No

Do you wear (circle): Glasses Contact Lenses

Medical History:

Do you have high blood pressure? Yes No

If yes, is it controlled by medication? Yes No

Do you have chest pain or heart palpitations with episodes? Yes No

Do you have a medical history of the following?

- Stroke/ TIA Yes No
- Heart disease Yes No
- Heart Surgery Yes No
- Neck or Back Injuries Yes No
- Head injury Yes No
- Metabolic Disorders Yes No

If you circled yes, please explain:_____

_____

_____

_____

Please list any medications that you are currently prescribed or are taking over the counter:_____

_____

_____

_____

Is there anything else you would like us to know about your dizziness or health history:_____

_____

_____

_____