FLORIDA E.N.T. & Allergy
Breathe Well. Hear Well. Be Well.

Name _____ **Date _____**

Dizziness Questionnaire

1. When did the dizziness first occur? (please describe in detail)
   _____
   _____
2. When dizzy, do you experience any of the following? (please mark yes or no)
   a. Light headedness ☐YES ☐NO
   b. Swimming Sensation in the head ☐YES ☐NO
   c. Objects spinning around you ☐YES ☐NO
   d. Sensation that you are spinning with outside objects remaining constant ☐YES ☐NO
   e. Tendency to fall (which way)_____ ☐YES ☐NO
   f. Loss of balance when walking ☐YES ☐NO ☐RIGHT ☐LEFT
   g. Blacking out ☐YES ☐NO
   h. Headache ☐YES ☐NO
   i. Loss of consciousness ☐YES ☐NO
   j. Nausea or vomiting ☐YES ☐NO
   k. Pressure in the head ☐YES ☐NO
3. Mark yes or no, and please describe if indicated
   a. My dizziness is constant ☐, in attacks ☐
   b. If in attacks how often do they occur _____, how long do they last_____?
   c. When was your last attack? _____
   d. Does your dizziness seem to be getting ☐ better or ☐ worse?
   e. Can you tell when the attack is about to start? ☐YES ☐NO
      i. Describe _____
   f. Does change of position make you dizzy? ☐YES ☐NO
   g. Do you know of anything that will:
      i. Make dizziness better? _____ ☐YES ☐NO
      ii. Make dizziness worse?_____ ☐YES ☐NO
      iii. Precipitate an attack?_____ ☐YES ☐NO
4. Mark yes or no
   a. Difficulty hearing? ☐RIGHT ☐LEFT ☐ BOTH
   b. Noise in ears? ☐RIGHT ☐LEFT ☐ BOTH
      i. Please describe_____
   c. Fullness in ears? ☐RIGHT ☐LEFT ☐ BOTH
   d. When did you first notice your hearing loss?_____
5. Do you experience the following?
   a. Double vision? ☐YES ☐NO ☐CONSTANT ☐EPISODES
   b. Blurred vision? ☐YES ☐NO ☐CONSTANT ☐EPISODES
   c. Difficulty with speech? ☐YES ☐NO ☐CONSTANT ☐EPISODES
   d. Numbness of extremities? ☐YES ☐NO ☐CONSTANT ☐EPISODES
6. Please list the medications you are currently taking
   _____
   _____
   _____
7. Do you smoke? ☐YES ☐NO If yes how much _____
8. Do you have a tendency to have motion sickness? ☐YES ☐NO

Dizziness Evaluation
Instructions

Videonystagmography (VNG) is as test designed to evaluate the portion of your inner ear responsible for balance (the vestibular system). This evaluation assists in determining the cause of the dizziness, vertigo, or imbalance. The results of this test will determine if your inner ear is contributing to your symptoms.

The day of your test
Discontinue any anti-vertigo medicines 48 hours prior to your scheduled visit; see below for a complete list of the medications you can take. Please do not wear any eye makeup as it interferes with the recording of test results. Eat light and wear comfortable clothing.

The entire test battery will take approximately one hour. Initially, a hearing test (if not performed at initial evaluation) and an evaluation of your balance will be completed. These two tests will be correlated with the VNG results.

The VNG
The VNG test is performed by watching your eye movements with a special pair of goggles as you do a variety of simple activities. This can be performed regardless of how well you see, and contact lenses can be worn. There are no needles used in the test, and it is not physically strenuous.

Following the hearing test and balance screening, the VNG has three parts:

1) Observation of your eye movements while seated. You will be asked to follow a light with your eyes, to stare in different directions, and to gently move your head side-to-side at different times.
2) Observation of your eyes while you are in varied physical positions. You will lie on your back, and be directed about how to move your head at different times.
3) Observation of your eyes while a gentle stream of air is placed into your ears one at a time. While comfortably reclined, the clinician will irrigate your ears with a mild flow of warm and cool air. This may cause a sense of motion during the procedure, which is artificial and temporary.

Note: It is impossible for any part of this test to make your symptoms worse.

Every portion of the test will be explained, and every effort will be made to ensure that your visit is pleasant and comfortable. Some people that are sensitive to motion may wish to arrange for someone to accompany them to the appointment or drive them home.

After the test
If immediate treatment for your symptoms is indicated, this will be explained. You will then follow-up with your ENT physician within one week for further review of the results, and for further medical recommendations.

Medications
Please do not take medications listed below for 48 hours prior to your test date. Certain medications can influence the body's response to the test, thus giving false or misleading results.

a. Alcohol: beer, wine, cough medicine
b. Analgesics-Narcotics: Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet
c. Anti-histamines: Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Hismanol, Claritin…any over the counter cold remedies.
d. Anti-Seizure medicine: Dilantin, Tegretol, Phenobarbital
e. Anti-vertigo medicine: Antivert, Ru-vert, Meclizine
f. Anti-nausea medicine: Atrax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal
g. Sedatives: Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill
h. Tranquilizers: Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Xanex
i. You may take blood pressure medications, heart medications, thyroid medications, Tylenol, insulin, estrogen, etc.

Always consult with your physician before discontinuing any prescribed medication