VESTIBULAR TESTING INSTRUCTIONS

VNG TEST INSTRUCTIONS

1. Balance testing may last anywhere from 1-2 hours. Due to the length of these appointments, a **48-hour** cancellation/reschedule notice is required. Please arrive 15 minutes before your scheduled appointment time to allow for check-in.
2. Please advise the office if you have poor vision without corrective lenses or have had any eye surgeries, including permanent makeup. Please speak with the Audiologist if you have any questions or concerns.
3. **DO NOT** take any **NONESSENTIAL** medications the day of your test.* Avoid:
    a. Anti-vertigo: including Meclizine, Antivert, Ru-vert
    b. Anti-histamines: including Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Hismanol, Clariton, or any OTC cold remedies
    c. Anti-depressants: including Elavil, Pamelor, Prozac, Lithium
    d. Anti-nausea: including Atrax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal
    e. Anti-Seizure: including Dilantin, Tegretol, Phenobarbital
    f. Narcotics/Barbiturates: including Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet
    g. Sedatives: including Halcion, Restoril, Nembutal, Seconal, Dalmane, Sleeping pills
    h. Tranquilizers: including Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Xanex
    i. Recreational Drugs
    j. **Allowed Medications**: essential/maintenance medications including blood pressure, heart, thyroid, Tylenol, insulin, estrogen, etc
4. **DO NOT** wear makeup, particularly eye makeup including mascara
5. **DO NOT** consume any caffeine or alcohol (beer, wine, liquor) 48 hours prior to your appointment
6. **DO NOT** eat or drink anything 4 hours prior to your testing**
7. Wear comfortable clothing
8. Call our office with ANY questions! We are happy to help!

***Always consult with your physician before discontinuing any prescribed medication**
****Light snack permitted for patients with diabetes**

Gardner Audiology

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CASE HISTORY/QUESTIONNAIRE (VNG)

Name: _____

Date: _____

Vestibular-Related Symptoms

A. Please indicate which of the following "dizziness-related" symptoms you have experienced:

__ Headache
__ Nausea
__ Vomiting
__ Spinning (you)
__ Spinning (the world around you)
__ Lightheadedness
__ Imbalance (*see below)
__ Falls (*see below)
__ Swimming sensation in head
__ Pressure in head
__ Difficulty walking in the dark
__ Cannot stand unsupported
__ Loss of consciousness
__ Sweating
__ Changes in hearing during an episode
__ Changes in tinnitus during an episode

*Loss of balance when walking: Veering to the __ Right __ Left __ Unknown

*Tendency to fall to the: __ *Right* __ *Left* __ *Forward* __ *Backward* __ *Unknown*

Severity of your symptoms: __ *Minimal* __ *Bothersome* __ *Severe* __ *Extreme*

Other symptoms: (please describe)

_____

_____

B. Onset and duration:

When did the symptoms first start? _____

Any changes in health, life, or medications around that time? __ *Yes* __ *No*

Description of the first episode. _____

_____

When was your most recent episode? _____

Frequency of dizziness: __ *Constant* __ *Intermittent attacks*

If intermittent attacks, how many attacks of dizziness occur per week? _____

Are you completely free of dizziness between attacks? __ *Yes* __ *No*

How long do attacks last? __ *Seconds* __ *Minutes* __ *Hours* __ *Days* __ *Weeks* __ *Months*

Can you explain what brings on or triggers an attack? (ex: head movement, sneeze/cough, etc.)

_____

Is there anything you can do to stop the attack? _____

C. Please list any pertinent medical conditions that may affect

Vision (such as Glaucoma, cataracts, etc): _____

_____

Movement (such as neck/spinal injuries, dislocated disks, hip replacement, etc): _____

_____

D. Additional Comments (if any): _____

_____

_____

Dizziness Handicap Inventory

Patient Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness.

To each question below, please place an "X" in the corresponding column" **Yes, No, Sometimes.**

An asnwer of "Yes" is 100% of the time, "No" is 0% of the time, and "Sometimes" is 1%-99% of the time.

Answer each question as it pertains to your dizziness or unsteadiness problem only.

	YES	NO	SOMETIMES
1) Does looking up increase your problem?			
2) Does walking down the aisles of a supermarket without a cart increase your problem?			
3) Does performing more ambitious activities like sports, dancing, or household chores increase your problem?			
4) Do quick head movements increase your problem?			
5) Does turning over in bed increase your problem?			
6) Does walking on the lawn increase your problem?			
7) Does bending over increase your problem?			
8) Because of your problem, do you restrict your travel for business or recreation?			
9) Because of your problem, do you have difficulty getting into or out of bed?			
10) Does your problem significantly restrict your participation in social activities?			
11) Because of your problem, do you have difficulty reading?			
12) Because of your problem, do you have someone accompany you when you leave home?			
13) Because of your problem, is it difficult for you to take care of yourself (i.e. bathe, dress, prepare a meal)?			
14) Because of your problem, is it difficult for you to walk around your house in the dark?			
15) Because of your problem, do you avoid driving your car in the daytime?			
16) Because of your problem, is it difficulty for you to go for a walk by yourself?			
17) Because of your problem, is it difficulty for you to walk up and down stairs?			
18) Because of your problem, do you avoid driving your car in the dark?			
19) Does your problem interfere with your job or household responsibilities?			
20) Because of your problem, is it difficult for you to concentrate?			
21) Because of your problem, do you feel frustrated?			
22) Because of your problem, are you afraid to stay home alone?			
23) Because of your problem, are you afraid people think you are intoxicated?			
24) Has your problem placed stress on your relationship with members of your family or friends?			
25) Because of your problem, are you depressed?			
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	x 4	x 0	x 2
=			
Total			

TINNITUS HANDICAP INVENTORY

Patient Name: _____ Date: _____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1. Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3. Does your tinnitus make you angry?	Yes	Sometimes	No
4. Does your tinnitus make you feel confused?	Yes	Sometimes	No
5. Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6. Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7. Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
8. Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Yes	Sometimes	No
10. Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11. Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13. Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14. Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15. Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16. Does your tinnitus make you upset?	Yes	Sometimes	No
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19. Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20. Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21. Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22. Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23. Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24. Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25. Does your tinnitus make you feel insecure?	Yes	Sometimes	No

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Total Per Column							
	x4		x2		x0		
Total Score		+		+		=	

To interpret the score please refer to the Tinnitus Handicap Severity Scale shown on the reverse side.

Newman, C.W., Jacobson, G.P., Spitzer, J.B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg, 122, 143-8.