Stetson Medical Center
541 Main Street, Suite 418
Weymouth, MA 02190
(781) 337-6860

South Shore Hearing Center

Suburban Hearing Aid
197 Rockland Street, Unit 3
Hanover, MA 02339
(781) 826-4711

# VIDEONYSTAGMOGRAPHY (VNG/ENG)

**VNG/ENG** is a series of tests designed to evaluate dizziness and related conditions. It is a non-invasive procedure. The test involves wearing goggles with video cameras to record eye movements called nystagmus.

There are three basic components to a VNG evaluation:

I. **Oculomotor (eye movement) testing:** During this portion of the test, the patient is sitting up and looking at a red dot as it moves on a light bar.

II. **Positional testing:** This patient will move into several positions during this part of the evaluation. These are ordinary positions, such as lying flat and turning the head to the right and left. There is no rapid movement during positional testing.

III. **Caloric testing:** Caloric testing is a painless procedure which evaluates the balance portion of the inner ear. Warm and cool air (six degrees above and below body temperature) will be separately circulated into each ear canal. Eye movements will be recorded to determine if there are any differences between the right and left ear.

Patients commonly ask if they will become dizzy during the evaluation. They may at certain times, but typically the dizziness will last no more than one minute. Most of the time the dizziness they do experience is far less than their own symptoms. At the conclusion of the testing, the patient will not feel any differently than when the testing began. Following review and test interpretation, a complete report will be sent to the referring physician within 48 hours.

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# VIDEO NYSTAGMOGRAPHY (VNG)

**APPOINTMENT: DATE:_____ TIME:_____**

## PATIENT INSTRUCTIONS

**Certain medications can influence the body's response to the test, thusgiving a false or misleading result. You will find a short list below, however,** if **you have any questions or concerns about discontinuing your medications, please consult your physician.**

**DO NOT TAKE** any of the following for **48 HOURS** prior to the test:

**ALCOHOL IN ANY QUANTITY:** beer, liquor, wine or cough syrup with alcohol.

**Anti-Dizziness medicine:** Meclizine, Antivert, Klonopin, Scopalomine patch, etc.

**Anti-Histamines:** Claritin, Zyrtec, Sudafed, Clarinex, Allegra, Chlor-trimetron, Dimetapp, Dimetane, Benadryl, Actifed, Hismanol, Teldrin, over-the-counter cold meds.

**Tranquilizers:** Valium, Librium, Atarax, Ativan, Serax, Yistaril, Xanex, Tranxene, Librax.

**Anti-Seizure Medicine:** Dilantin, Phenobarbitol, Tegretol **(Check with physician before discontinuing!!!!)**

**Sedatives:** Halcion, Restoril, Nembutol, Dalmane, Seconal, any sleeping pills.

**Anti-Nausea Medicine:** Atarax, Dramamine, Compazine, Bucladin, Phenergan, Thorazine, Scopalomine patch.

**Analgesics/Narcotics:** Codine, Demerol, Percocet, Darvocct, Phenafen, Tylenol with codine.

You **MAY TAKE** blood pressure meds, hear/cholesterol meds, thyroid medication, Advil/Tylenol, insulin, estrogen, etc. **Always check with your physician before discontinuing any prescribed medications.**

**Please do not eat for 2 hours prior to your appointment.** If your appointment is in the morning, you may have a light breakfast such as toast or juice. If you are coming in the afternoon, eat breakfast and have a light snack for lunch. **Please avoid caffeine in beverages such as coffee, tea and soft drinks for 4 hours prior to testing.**

Women are asked to wear pants or shorts for testing. Gentlemen are asked to wear loose fitting clothes for comfort during testing. **Please refrain from wearing any skin lotions, moisturizing creams, makeup, mascara etc., on your face the day of the testing.**

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# VNG Questionnaire

**Name:**_____ **Phone #:**_____

**Date of Birth:**_____ **Occupation:**_____

**Address:**_____

**City:**_____ **State:**_____ **Zip code:**_____

**Referring Physician:** _____

**Family Physician, if different:** _____

**Initial Problem:**
Please describe the problem(s) you are seeking help with: _____

_____

When did the problem begin? _____

What were the initial symptoms and circumstances? _____

Do the symptoms occur in attacks? YES NO How often? _____ How long do they last? _____

What have you been told the problem is due to? _____

What do you think it is due to? _____

Please circle the following words that describe your problem(s)

| | | | |
|---|---|---|---|
| Giddy | Lightheaded | Off-balance | Disoriented |
| Spinning | Tumbling | Dizziness | Rocking |
| Tilting | Other: _____ | | |

Have these symptoms improved since the problem(s) began? _____

When are the symptoms mostly present

Walking standing sitting lying down

Movement from one position to another