ENT and Allergy Associates of Florida
Caring For Our Patients Since 1963
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Several tests will be performed during your appointment. *We strive to make your visit comfortable and educational*. Once your evaluation is complete, a report will be forwarded to your physician.

INFORMED CONSENT AGREEMENT

During a portion of the balance testing you will be asked to follow a series of lights with your eyes. You will be directed to move into different head and body positions while your eye movements are observed. During the final part of the test, cool and warm air will be introduced into your ear canals while your eye movements are observed. This may cause a sensation of motion which will dissipate quickly.

Patient / Guardian Printed Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____Signature of Witness: _____

Patient Instructions

- **VERY IMPORTANT: Bring completed Balance Questionnaire to your appointment.**
- We encourage you to have someone bring you to and from the appointment as a sensation of motion may linger. However, if this is not possible, please include an extra 15-30 minutes after your test before leaving the office.
- Do not wear contacts, makeup or use face lotions.
- Wear comfortable clothing. Skirts and/or dresses are not recommended.

12 hours prior to the test

- Please eat lightly 12 hours prior to the test - if your appointment is in the morning you may have a light breakfast such as toast or juice. If your appointment is in the afternoon please eat a light breakfast and have a light snack for lunch.
- Avoid caffeine in beverages such as coffee, tea or soft drinks as well as chocolate.

48 hours prior to test

- Certain medications can influence the test results. The list below includes medicines that you should refrain from taking 48 hours (2 days) prior to your test. *If you have any question or concerns about discontinuing any medications, please consult your doctor.*

Alcohol: Liquor, beer, wine, cough medicine. **Analgesics –Narcotics**: Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet. **Anti-histamines**: Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin…any over-the-counter cold remedies. **Anti-seizure medicine**: Dilantin, Tegretol, Phenobarbital. **Anti-vertigo medicine**: Antivert, Ru-vert, Meclizine. **Anti-nausea medicine**: Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal. **Sedatives**: Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill. **Tranquilizers**: Valium, Klonopin, Libruim, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanex, Zoloft, Diazepam. (*medication list from "The American Institute of Balance")*

You **MAY TAKE** blood pressure medication, heart medications, thyroid medications, Tylenol, insulin, estrogen. **Always consult with your physician before discontinuing prescribed medication.**

ENT and Allergy Associates of Florida / ENT Hearing Associates of South Florida
Videonvstagmography (VNG) Questionnaire

I. Present illness: I am here because of (circle all that apply):

Dizziness (such as vertigo) Imbalance Hearing problem (hearing loss, tinnitus, fullness)

II. Symptoms

My symptoms started on: _____

My symptoms come in: **Attacks** or are **Constant**

If in attacks:

How often? _____

How long do they last? _____

Do you have any warning that they are about to start? _____

What? _____

Did you have any illness at the time of the initial episode? _____

Were you exposed to any irritating fumes, paints, etc. at the onset of the symptoms? _____

Did you have a neck or head injury? _____

Did/do you experience any of the following while dizzy *(Place an "**X**" under applicable response):*

Yes	**No**	
____	____	1. Spinning or turning, while objects are stationary
		If yes, does it occur mostly when you
		_____ lay down _____ roll to the right
		_____ roll to the left _____ look up on to a shelf
____	____	2. Visual blurring or jumping during head motion
____	____	3. Loss of balance when walking: _____Veering to the right _____Veering to the left
____	____	4. Fall(s): _____ to the right _____ forward
		_____ to the left _____ backward
____	____	5. Swimming sensations in your head
____	____	6. Light-headedness
____	____	7. Blacking out or loss of consciousness
____	____	8. Headache or head pressure
____	____	9. Nausea or vomiting
____	____	10. Other: _____

III. Triggers

Are your dizziness, vertigo, imbalance, or hearing problems affected or brought on by:

Yes	No		Yes	No	
____	____	I. Changes in position of the head or body	____	____	9. Narrow or wide open spaces
____	____	2. Standing up	____	____	10. Exercise
____	____	3. Rapid head movement's	____	____	11. Foods - salt, MSG
____	____	4. Walking in a dark room	____	____	12. Time of day, particular seasons
____	____	5. Elevators	____	____	13. Stress
____	____	6. Airplane, boat, or car travel	____	____	14. Alcohol
____	____	7. Loud noises	____	____	15. Headache / Migraine
____	____	8. Coughing, blowing your nose, or straining	____	____	16. Menstrual periods (if relevant)
____	____	17. Other: _____			

IV. Ear Problems

Have you ever had?

1. Loss of hearing?	No	Right	Left	Both
2. Abnormal sounds in ear?	No	Right	Left	Both
Describe the noise: _____				
Does it change when you have symptoms? _____				
Does anything make the noise better or worse? _____				
3. Fullness or pressure in ear?	No	Right	Left	Both
4. Pain in ear?	No	Right	Left	Both
5. Distortion or sensitivity to sound?	No	Right	Left	Both
6. Do you use a hearing aid?	No	Right	Left	Both
7. Noise exposure/trauma?	No	Right	Left	Both
8. Ear surgery?	No	Right	Left	Both

V. Fall Risk

Yes	No	
____	____	1. Have you fallen in the past year?
____	____	2. Have you fallen in the past two (2) years? Amount of falls _____
____	____	3. If you have answered yes to question #2, were you injured in any way (skin tear included)?
____	____	4. Are you worried that you may fall?
____	____	5. Do you have any difficulty rising from a chair?
____	____	6. Do you have any problems with your feet such as pain or numbness?

VI. Other significant history

Please answer the following questions regarding other possible significant history.

Yes	No	(if yes, please report on onset of symptoms and any current/past treatment)
____	____	1. Allergies? _____
____	____	2. Diabetes? _____
____	____	3. Migraines? _____
		a. If so, what are your typical symptoms? _____
		b. If so, do you take medication to help with symptoms? _____

Yes **No** (continued)

____ ____ 4. Anxiety and/or depression? Past or Present? _____
____ ____ 5. Tobacco use within the last 24 months? _____
____ ____ 6. Alcohol use. How much daily/weekly? _____
____ ____ 7. Caffeine intake (coffee, tea, soda, chocolate, etc.)? How much daily? _____
____ ____ 8. New glasses? If so, when was last eye exam? _____
____ ____ 9. High or low blood pressure? If yes, is this presently being managed? _____
____ ____ 10. Heart disease? _____
____ ____ 11. Seizure? _____
____ ____ 12. Memory loss? _____
____ ____ 13. Difficulty swallowing? _____
____ ____ 14. Difficulty walking or slurred speech? _____
____ ____ 15. Weakness of arms or legs? _____
____ ____ 16. Numbness or tingling of the face or extremities? _____
____ ____ 17. Body pain. Where & when did symptoms start? _____
____ ____ 18. Cancer. What type and when? _____
____ ____ 19. Eye problems (other than glasses)? Please explain. _____
____ ____ 20. What sort of work do you do (used to do)? _____
____ ____ 21. Family history of dizziness, balance, or hearing symptoms? Explain: _____
____ ____ 22. Motion Sickness? (When riding on boats, in airplanes or cars?) _____
____ ____ 23. Recent or episodic upper respiratory infection (URI)? _____
____ ____ 24. Shingles? _____
____ ____ 25. Hormone Changes? (Menstrual cycle changes, birth control, pregnancy, etc.):_____
____ ____ 26. Other: _____

VII. Previous Studies

Yes **No**

____ ____ 1. Ear tests (hearing, ABR, VNG, etc.)? _____
____ ____ 2. Neurological tests (EEG, cerebral angiogram, carotid Doppler, etc.)? _____
____ ____ 3. General medical tests (blood tests, EKG, tilt table, etc.)? _____
____ ____ 4. Scans (X-Ray, MRI, CT, etc.)? _____

VIII. Medications:

Have you taken any of the following medication in the last 48 hours?

Yes **No** Condition Medication is treating
____ ____ a. Dizziness Medicines
____ ____ b. Pain Medicine or Sedatives
____ ____ c. Anxiety/Tranquilizers
____ ____ d. Antihistamines
____ ____ e. Antidepressants
____ ____ f. Anti-seizure medication
____ ____ g. Alcoholic beverages
____ ____ h. Caffeine beverages

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