Northwest
Speech and Hearing Center Ltd.

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VESTIBULAR CASE HISTORY

Patient Name_____

Patient DOB_____

You have indicated that you have imbalance, dizziness or vertigo. Please answer the following questions by circling the appropriate **bold response** or answering in the blank space provided.

1. I first experienced my problem_____. My most recent episode occurred_____.
2. Which of the following most closely resembles your problem? Mark all that apply:
    - Light-headedness
    - Swimming sensation in the head
    - Rocking/swaying motion
    - Objects spinning or turning around you
    - Sensation that you are turning or spinning inside while outside objects remain stationary
    - Loss of balance when walking
        - Veering to the right
        - Veering to the left
    - Tendency to fall
        - To the left
        - To the right
        - Forward
        - Backward
    - Blacking out or loss of consciousness
    - None of the above. More like_____
3. Were you exposed to irritating fumes/paints/etc. when the problem started? **Yes**/**No**
4. Did you have a head injury prior to the onset of your problem? **Yes**/**No**
    - Did you have a concussion? **Yes**/**No**
5. Were you ill with a cold/flu/covid/other illness at the onset of your problem? **Yes**/**No**
6. Do you take any medications for this problem? **Yes**/**No**
    - What medication?_____

PLEASE CONTINUE TO THE OTHER SIDE

7. I have this sensation: **all of the time/some of the time/occasionally**. Symptoms **are constant** (never goes away)/**fluctuate** (come and go).
8. I **do/do not** have isolated attacks of vertigo that come _____times a **day/week/month/year**.
9. When it occurs, the sensation typically lasts _____**seconds/minutes/hours/days**. It takes **seconds/minutes/hours/days** for me to completely regain my balance after the motion ceases.

10. When I experience my symptoms, I also have (mark all that apply):

Ear ringing	**Ear Fullness**	**Ear Pain**	**Hearing Changes**	**Sound Distortion**
Headache	**Pressure in the Head**	**Nausea**	**Vomiting**	**Numbness/Tingling**
Visual Changes	**Falls**	**Loss of Consciousness**	**Other_____**	

11. What triggers your problem? _____

12. What makes it worse?_____

13. What makes it better?_____

14. Do you have any of the following: (Mark all that apply)

- Double Vision **Constant/In Episodes**
- Weakness in Arms or Legs **Constant/In Episodes**
- Clumsiness in Arms or Legs **Constant/In Episodes**
- Confusion/Fogginess **Constant/In Episodes**
- Difficulty with speech **Constant/In Episodes**
- Difficulty with swallowing **Constant/In Episodes**
- Tingling around the mouth **Constant/In Episodes**

15. Do any of the following apply to you? (Mark all that apply)
    - I get dizzy/off-balance after exertion
    - I recently changed my glasses
    - I tend to get upset easily
    - I am dizzy/light-headed/off-balance when I have not eaten for a long period of time
    - My problem occurs before/during my menstrual cycle

VIDEONYSTAGMOGRAPHY (VNG) PATIENT INSTRUCTIONS

Your doctor has ordered a test of the inner ear balance system called VNG (videonystagmography). The test battery also includes a hearing evaluation and an evaluation of a muscle reflex in your ears. The testing is scheduled for 1.5 hours.

The VNG is based on involuntary eye movements called nystagmus. During the test you will wear video goggles that allow the audiologist to observe and measure these eye movements as well as others that are associated with your inner ear and brain mechanisms that control balance. Your visual acuity does not affect the test.

During the VNG, you will be using your eyes to watch and follow different lights and patterns; your head and body will be moved into different positions on the exam table; the audiologist will blow warm and cool air into your ears to stimulate the balance organs. You may experience dizziness during the testing, although most patients state it is mild in comparison to their problem. A driver is not required, but may be helpful because some people are more sensitive to the dizziness than others.

Fill out the attached vestibular questionnaire and bring it with you. **Please arrive 15 minutes prior to your appointment time. Late arrivals may result in rescheduling all or part of your evaluation.**

VNG TEST INSTRUCTIONS—failure to follow these may result in rescheduling your appointment.

- **DO NOT** eat for 4 hours prior to the test; keep liquids to a minimum.
- **DO NOT** consume alcohol for 24 hours prior to testing.
- **DO NOT** take any anti-dizziness or anti-nausea medications for 48 hours prior to the test (eg., Meclizine, Antivert, Dramamine, Scopolamine patches, Zofran, Phenergan, Bonine)
- **DO NOT** take any antihistamines for 48 hours prior to the test (eg, Benadryl, Allegra, Claritin, Zyrtec, Chlor-Trimeton, etc.).
- **DO NOT** take over the counter cough or cold medications for 48 hours prior to the test.
- **DO NOT** take any marijuana, narcotics, sedatives, tranquilizers, sleeping pills or stimulants for 48 hours prior to the test.
- **DO NOT** wear any makeup including mascara or false eye lashes.
- **CONTINUE** any life-sustaining medications such as water pills, blood thinners, seizure medications, heart and blood pressure medications, diabetic medications, etc. Continue any antibiotics or steroids you have been prescribed.

Appointment Location: 880 West Central Rd, Suite 4300 Busse Center at NCH

Appointment Date and Time:_____