VIDEO-ELECTRONYSTAGMOGRAPHY PATIENT INSTRUCTIONS

You have been referred to our office for an assessment of your vestibular system. The test is called a Video-electronystagmography (VNG). A VNG is a test of the balance mechanism. The test will take approximately 1 hour to complete. It is not painful. Please follow the instructions below so that your test results will be valid.

- 1) Do not take any of the following for 48 hours prior to the test. Please do contact your doctor if you have reservations about discontinuing any medication.

Anti-nausea Medicine: Dramamine, Compazine, Bonine, Marezine, Vontrol, Pheregan, Thorazine, etc…
Anti-Vertigo Medicine: Anti-vert, Ru-Vert, Meclizine, etc…
Tranquilizers: Valium, Librium, Atarax, Vistaril, Equinil, Miltown, Triavil, Serax, Etrafon, etc…
Sedatives: Nembutal, Seconal, Dalmane, Doriden, Placidyl, Quaalude, Butisol, or any other sleeping pill.
Narcotics & Barbiturates: Phenobarbital, Codeine, Demerol, Dilaudid, Percodan, Phenaphen, etc…
Antihistamines: Chlor-trimetan, Dimetane, Disophrol, Benadryl, Actifed, Teldrin, Triaminic or any other over the counter cold remedies.
Alcohol in any quantity: Including beer, wine, and any cough medicines containing alcohol.
Caffeine: discontinue for 24 hours

If you have any reservations about discontinuing any medications, consult your doctor. Medication for diabetes, hypertension or heart disease **SHOULD NOT BE DISCONTINUED**. If you have any questions regarding the effect of any medications on the test, please call our office.

- Sleep a full night before the test.
- Please eat a light meal approximately two hours before the test.
- Please **do not wear make-up** around your eyes including: mascara, eyeliner, and eyeshadow.
- Please do not use any facial moisturizer or foundation.
- Do not wear contact lenses, bring your glasses.
- Do wear loose, comfortable clothing.

Your appointment has been scheduled for _____ at_____.
Please bring your insurance card, photo ID, and script from _____. If you have any questions or need to reschedule your appointment, please call our Staten Island office. Thank you.

Patient name_____ Date_____

DIZZINESS QUESTIONAIRE

Please answer all of the following questions by circling or bolding the appropriate responses and/or filling in relevant blanks.

CHARACTERIZE YOUR DIZZINESS

Yes No 1. Lightheadedness, faintness, giddiness.
Yes No 2. Unsteadiness.
Yes No 3. I or my surroundings seem to be moving.
Yes No 4. I am able to go on with my usual activities while dizzy.
Yes No 5. I am able to go on with only some of my usual activities while dizzy.
Yes No 6. I am completely incapacitated and must go to bed while dizzy.

ONSET AND COURSE

7. Date of first dizziness_____
Yes No 8. My dizziness is constant.
Yes No 9. My dizziness come in attacks.
10. If in attacks, how often? Hourly Daily Weekly Monthly
11. How long do they last? Seconds Minutes Hours Days
Yes No 12. My dizziness comes on suddenly.
Yes No 13. My dizziness comes on gradually.
Yes No 14. I am completely free of dizziness between attacks.
Yes No 15. I can tell when an attack is about to start.
Describe how_____

ASSOCIATED SYMPTOMS

Yes No 16. Nausea or vomiting?
Yes No 17. Sweating?
Yes No 18. Deafness or difficulty hearing? Right Ear Left Ear Both Ears
Yes No 19. Any noises (buzzing or ringing in ears)? Right Ear Left Ear Both Ears
Yes No 20. Change in this noise with dizziness?
Yes No 21. Fullness or pain in ears? Right Ear Left Ear Both Ears
Yes No 22. Drainage from ears? Right Ear Left Ear Both Ears
Yes No 23. Tendency to fall? Right Left Either
Yes No 24. Tendency to veer when walking? Right Left Either

Yes No 25. Headache or pressure in head? During After
Where?_____

Yes No 26. Double vision, blurred vision or blindness?

Yes No 27. Weakness or clumsiness in arms or legs?

Yes No 28. Difficulty with speech or swallowing?

Yes No 29. Blackouts, loss of consciousness, confusion or loss of memory?

Yes No 30. Rapid heartbeat or palpitations?

Yes No 31. Shortness of breath during the attack?

Yes No 32. Numbness or tingling of face, fingers or toes?

Yes No 33. Pain or stiffness of the neck?

EXACERBATING AND REMITTING FACTORS

Yes No 34. Does turning your head bring on or make your dizziness worse?
Which direction?_____

Yes No 35. Does lying down or sitting up bring on your dizziness?

Yes No 36. Does standing up bring on your dizziness?

Yes No 37. Do you find it especially difficult to walk in the dark?

Yes No 38. Is there any relationship between your dizziness and tension or anxiety in your life? Explain:_____

Yes No 39. Do you know of anything that will precipitate an attack?
What?_____

Yes No 40. Do you know of anything that will stop or make your dizziness better?
What?_____

PRESENT/PAST MEDICAL HISTORY

Yes No 41. Have you ever had a concussion, skull fracture, or been knocked unconscious?

Yes No 42. Have you ever had a whiplash or do you have a neck disease?

Yes No 43. Do you have an eye disorder or wear glasses?

Yes No 44. Have you ever had ear infections or other ear disease?

Yes No 45. Had you been taking prescription or nonprescription medications regularly before your dizziness started?
If so, list them._____

Yes No 46. Do you have any allergies? If so, to what?_____

Yes No 47. Have you in the past or do you now smoke? Packs per day____
Years_____

Yes No 48. Have you in the past or are you now a heavy drinker?

Yes No 49. Have you in the past or do you now have: Diabetes
High Blood Pressure Migraine Seizures Cancer Stroke Heart Attack

Yes No 50. Do you know of any possible cause of your dizziness?
What?_____

Yes No 51. Has another doctor done tests to evaluate your dizziness?
Dr._____ Phone ( )_____ Date_____

Yes No 52. Do you wear an intracardiac catheter or pacemaker with exposed leads?

_____PLEASE GIVE INSURANCE CARD TO SECRETARY TO COPY____

STATEN ISLAND AUDIOLOGICAL SERVICES

Please Print Clearly

Patient: **This section refers to the ***patient only*****

Name:_____Age:_____Date of Birth:_____Marital Status:_____
Last First

Address:_____Sex:_____ Email address:_____

City:_____State:_____Zip:_____Employer:_____

Home Phone:( )_____Address:_____

Cell Phone: **(**)_____City:_____State:_____Zip:_____

Family Member: ( )_____

BILLING:** ***Please complete if person responsible for bill is other than patient**

Name:_____Relationship to Patient:_____
Last First

Street Address:_____Insured's Date of Birth:_____

City:_____State:_____Zip:_____Home Phone:( )_____

Employer:_____Address:_____

Work Phone:( )_____City:_____State:_____Zip:_____

PLEASE SUPPLY US WITH YOUR INSURANCE COVERAGE. If you have more than one carrier, supply information on both. **PLEASE LIST ALL NUMBERS ON YOUR CARD(s).**

Primary Company:_____Secondary Company:_____

Address:_____Address:_____

Name on I.D.card_____Name on I.D.card_____

Relationship to patient (Please check) Relationship to Patient (Please Check)

Self____Spouse____Parent____Other____ Self____Spouse____Parent____Other____

Insured I.D. #:_____ Insured I.D. #:_____

Group #:_____ Group #:_____

Signature_____Date_____Referred by_____

PATIENT NAME:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____Date: _____

REQUEST FOR RELEASE OF INFORMATION

I authorize **Staten Island Audiological Services** to release information to the following:

Name: _____
Address: _____

Signature: _____Date: _____

PATIENT'S AUTHORIZATION – CERTIFICATION FORM

INSURANCE CO: _____ID #: _____

I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefit to either myself or the audiologist, if the fee has not been paid. I understand I am financially responsible for any balance not covered by my insurance carrier.

Signature: _____Date: _____

OR

INSURANCE CO: MEDICARE ID #:_____

I request that payment of authorized Medicare benefits be made either to myself or on my behalf to SI Audiological Services for any services furnished me by that audiologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I also understand that Medicare does not cover the cost or related cost of a hearing system.

Signature: _____Date:_____

ADULT AUDIOLOGICAL HISTORY

NAME:_____ Date of Birth:_____Age:_____
Referral Source:_____Primary Doctor:_____
Occupation (Current or prior to retirement)_____

Are you experiencing hearing loss? Y N If so, which ear? Right Left Both
Duration of hearing loss? _____
Have you ever worn a hearing aid? Y N If so, for how many years? _____
When was your last hearing test? _____ Where was the test performed?_____

Have you been diagnosed with any of the following: Dementia /Alzheimer's Parkinson's disease
Neurological disorder Other:_____
Are you experiencing memory difficulties Y N _____

Diabetes	Y	N	_____
Dizziness	Y	N	_____
Ear Disease/Surgery	Y	N	When?_____
Ear Infection/Hole in Eardrum	Y	N	_____
Tinnitus (Noise/Music in ear)	Y	N	_____
Head Trauma/Concussion	Y	N	_____
Heart Disease	Y	N	_____
Kidney or Liver Disease	Y	N	_____
Chronic Sore Throat	Y	N	_____
Loss of Sense of Smell	Y	N	_____
Cancer	Y	N	_____
Hepatitis C	Y	N	_____
Auto Immune Disease	Y	N	_____
Family History of Hearing Loss	Y	N	_____
Spinal/Back/Neck issues	Y	N	_____
Skin Disorder	Y	N	_____
Allergies/Asthma	Y	N	_____
Seizure disorder	Y	N	_____
Sinus disease	Y	N	_____
Thyroid Disease	Y	N	_____

Do you work or have ever worked in a noisy environment? Y N
Do you engage in noisy recreational activities such as shooting, riding a motorcycle, attending concerts, playing a musical instrument etc? Y N
Have you had an MRI or a CT scan of the head in the past one year? Y N
Have you seen an ENT (ear nose and throat) specialist Y N If so, when? _____
Recent hospitalizations: _____
Recent/ New Medication: _____
Other Medical Problems: _____
Comments:_____

_____ _____
PATIENT'S SIGNATURE **DATE**

Please provide COMPLETE list of medication (prescription, over the counter, supplements and vitamins) that you are currently taking.

Are you taking blood thinners? Y N_____

Medication	**Dosage**	**Frequency**