SCENT
ALLERGY & SLEEP MEDICINE

Name: _____

VNG Appointment Date &Time: _____

☐ Lugoff Office
15 Exchange Dr.
Lugoff, SC 29078
803-424-2208

☐ Downtown Columbia Office
3 Richland Medical Park Dr. #100
Columbia, SC 29203
803-419-1640

We will file with you insurance company for payment of this test on your behalf. Please be aware that you will be responsible for any co-pay or deductible that you may have with your insurance company.

It is very important for you to read the attached directions very carefully as soon as possible. Please complete the attached questionnaire and bring it with you on the day of your appointment.

The test will take approximately 60 minutes to complete, so please be on time for your appointment.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure recommended so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to alarm you, it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I (we) voluntarily request the Providers of South Carolina ENT, Allergy, & Sleep Medicine, as my physician and such associated technical assistants and other health care providers as he/she may deem necessary, to treat my condition which has been explained to me.

I (we) understand the following diagnostic procedures are planned for me and I (we) voluntarily consent and authorize the following procedure: **Videonystagmography.**

I (we) understand that no warranty or guarantee has been made to me a result of care.

I certify this form has been fully explained to me and that I have read it or have had it read to me. I understand its contents. I certify that I have been given both the 1) Instructions for VNG testing and 2) VNG Case History Questionnaire.

_____

Signature of Patient or other legally responsible person Date

_____

Witness to Signature Date

Instructions and what to expect from your VNG

PLEASE READ CAREFULLY 48 HOURS BEFORE TESTING!

A VNG (videonystagmography) test has been scheduled for you in an effort to assist your physician in determining the cause of your symptoms. The VNG consists of a battery of tests that contribute information on the condition of your balance system. The exam takes approximately one hour and should not cause you pain. You may experience brief episodes of dizziness during some portions of the test. Your test results will be interpreted, correlated with other clinical findings, and your physician will review the findings with you at your follow up appointment.

Certain substances that affect the Central Nervous System (CNS) can influence your responses on this test. Therefore, you must refrain from certain medications and alcohol (including beer, wine, and mixed drinks) for 48 hours before testing. There is a partial list of medications on the following page which need to be avoided for 48 hours before testing.

DO NOT refrain from LIFE SUSTAINING MEDICATIONS! Please contact your prescribing physician should you have any reservations about discontinuing any medication.
If you have any questions about medications that you are currently taking, please call our office for clarification.

In addition, please refrain from eating for 4 hours before testing. IF YOU ARE DIABETIC, DO NOT ALTER YOUR CURRENT DIET OR DIABETIC MEDICATION REGIMEN. Please wear comfortable clothing. Ladies may prefer to wear pants. Due to the sensitive nature of the infrared goggles used for testing, patients are prohibited from wearing eye and facial make-up (including eyeliner, eye shadow, mascara and false eye lashes). Contact lenses are permissible. You may be asked to remove any earrings.

If the patient is under the age of 18, he or she must be accompanied by a parent or legal guardian. Children are not permitted in the exam room during testing. Children are not permitted to remain in the waiting area unless attended by a parent or legal guardian.

Please arrange for transportation home after the test, or have possible transportation on standby. You may experience dizziness for a short period after the test. While many patients feel safe to drive themselves home, we cannot anticipate how you may respond to the test.

Failure to comply with these instructions will compromise test results and may result in your test being rescheduled for another day. Please notify the office within 24 hours if you cannot keep this appointment.

MEDICATIONS TO BE STOPPED 48 HOURS BEFORE VNG TESTING

This list is NOT all inclusive.

*If you have any questions regarding your medications, please call our office at 803-424-2208 for verification at least **2 full days** before testing.*

Over-the-counter medications: all allergy medications
all cold medications
all sleep aids
anti-itch creams containing antihistamines
cough syrups

Allergy Meds
Allegra
AlleRx
Antihistamine sprays
Astelin nasal spray
Astepro nasal spray
Benadryl
Claritin
Clarinex
Nolamine
Pataday eye drops
Patanase nasal spray
Zyrtec

Pain Meds
Darvocet
Demerol
Dilaudid
Lortab
Morphine
Oxycontin
Oxycodone
Paxicodone
Percocet
Phrenilin
Topamax
Vicodin
Wygesic
Zydone

Dizziness/Nausea/Diarrheal
Antivert
Atarax
Compazine
Dramamine
Meclizine
Phenergan
Scopolamine patch
Zofran

Herbal remedies
Ginkgo
Valerian

Psychotherapeutic Agents/ Antidepressants/Sedatives
Ativan
BuSpar
Celexa
Clorazil
Concerta
Dalmane
Depakote
Effexor
Elavil
Halcion
Haldol
Klonopin
Librium
Lithium
Lorazepam
Nembural
Milltown
Paxil
Prozac
Ritalin
Restoril
Seconal
Sedatives
Serax
Sinequan
Sleeping Pills
Stelazine
Stratera
Tranxene
Trazadone
Triavil
Valium
Vivactil
Wellbutrin
Xanax
Zoloft
Zyprexa

Restless Leg
Requip
Mirapex

****Seizure Meds****
Dilantin
Mebaral
Tegretol
Phenobarbital
check with your doctor before stopping these medications

Other
Neurontin

THE FOLLOWING MEDICATIONS ARE ALLOWED PRIOR TO TESTING: Heart medications, cholesterol medications, glaucoma, blood pressure medications, thyroid medications, diabetes medications, reflux medications, hormone treatment, birth control pills, Imitrex, asthma inhalers, regular/plain Tylenol & Advil, antibiotics, Kaopectate, Imodium, and Pepto Bismol.

DIZZINESS HISTORY QUESTIONNAIRE

Name:_____ Age:_____ Date: _____

WHEN was the first time you ever had dizziness?_____

_____

WHAT were the circumstances? _____

WHEN was the last time you experienced dizziness? _____

WHAT were the circumstances? _____

_____

CURRENTLY, MY DIZZINESS…

- ☐ is constant.
- ☐ is always there, but changes in intensity.
- ☐ comes in episodes.

IF COMES AND GOES:

How long does it typically last? ___ seconds / minutes / hours (Circle ONE)
How often does it typically occur?_____ times per: hour / day / week / month / year

MY DIZZINESS MOSTLY CONSISTS OF…(Check ALL that apply)

- ☐ spells of spinning with nausea.
- ☐ off-balance sensation.
- ☐ a light-headed or near faint sensation.
- ☐ other. Please explain _____

BETWEEN EPISODES I FEEL…(Check ONE)

- ☐ dizzy or off balance all the time.
- ☐ normal.
- ☐ other. Please explain _____

MY EPISODES OCCUR…(Check ALL that apply)

- ☐ spontaneously. Nothing I do seems to bring them on or turn them off.
- ☐ only when standing or walking.
- ☐ in relation to any head motion.
- ☐ only in certain head positions. Please describe _____

WHEN I ROLL OVER IN BED…(Check ONE)

- ☐ nothing unusual happens.
- ☐ the room seems to spin sometimes.

IS THERE ANYTHING THAT YOU CAN DO TO MAKE YOUR DIZZINESS GO AWAY?
(sit, lay down, close eyes…)

Please explain: _____

_____

QUESTIONNAIRE

DIZZINESS HISTORY QUESTIONNAIRE

CIRLCLE ALL THAT APPLY:

I have hearing difficulty *Right / Left / Both*
I have ear fullness *Right / Left / Both*
I have ringing or other sounds *Right / Left / Both*
I have had ear surgery *Right / Left / Both*

CIRCLE YES OR NO

- Did you have cold, flu or virus type symptoms shortly before the onset of your dizziness? .....YES / NO
- Did you cough, lift, sneeze, fly in a plane, swim under water or have a head trauma shortly before the onset of your dizziness? .....YES / NO
- Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness? .....YES / NO
- Do you get dizzy when you have not eaten for a long time? .....YES / NO
- Is your dizziness connected with your menstrual period? .....YES / NO
- Did you get new glasses recently? .....YES / NO
- I consider myself to be an anxious or tense type of person... .....YES / NO

IN THE PAST YEAR I HAVE HAD...(CHECK ALL THAT APPLY)

❑ loss of consciousness ❑ occasional loss of vision ❑ seizures or convulsions
❑ severe pounding headache or migraine ❑ slurring of speech ❑ difficulty swallowing
❑ palpitations of the heartbeat ❑ weakness in one hand, arm or leg ❑ tingling around mouth
❑ double vision ❑ tendency to fall ❑ spots before the eyes ❑ loss of balance when walking

I HAVE OR HAVE HAD...(CHECK ALL THAT APPLY)

❑ Diabetes ❑ Stroke ❑ High blood pressure ❑ Migraine headaches ❑ Arthritis
❑ A neck and/or back injury ❑ Irregular heartbeat ❑ Allergies

PLEASE CHECK BELOW FOR ANY MEDICATIONS YOU HAVE TRIED FOR DIZZINESS OR ARE CURRENTLY TAKING:

	Taken in past	Taking now	Helps
Antivert (Meclizine)	___	___	___
Valium (Diazepam)	___	___	___
Dyazide "water pills"	___	___	___

HAVE YOU EVER BEEN PREVIOUSLY EVALUATED FOR DIZZINESS?

Where? When? _____

_____