Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Label Here***

***Videonystagmography (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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Label Here***

**III. Triggers**

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

**Yes No Yes No**

\_\_\_ \_\_\_ 1. Changes in position of the head or body \_\_\_ \_\_\_ 9. Narrow or wide open spaces

\_\_\_ \_\_\_ 2. Standing up \_\_\_ \_\_\_ 10. Exercise

\_\_\_ \_\_\_ 3. Rapid head movements \_\_\_ \_\_\_ 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Fullness or pressure in ear? No Right Left Both
2. Pain in ear? No Right Left Both
3. Distortion or sensitivity to sound? No Right Left Both
4. Do you use a hearing aid? No Right Left Both
5. Noise exposure/trauma? No Right Left Both
6. Ear surgery? No Right Left Both

**V. Fall Risk**

**Yes No**

\_\_\_ \_\_\_ 1. Have you fallen in the past six (6) months?

\_\_\_ \_\_\_ 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?

1. If so, what are your typical symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If so, do you take medication to help w/ symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Label Here***

**Yes No** (if yes, please report on onset of symptoms and any current/past treatment)

\_\_\_ \_\_\_ 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 & when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 19. Eye problems (other than glasses) What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. What sort of work do you do (used to do)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 21. Family history of dizziness, balance, or hearing symptoms? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 22. 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**

***Length of time on medication***

Please list your current medications and why they are taken.

***Medications*** ***Condition that medication is treating*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which medications have you taken in the past **48 hours** (prior to VNG testing)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_