EASTERN SHORE
ENT & Allergy
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Please fill out the following case history to the best of your ability. Please be brief, as we will address these questions in detail during your appointment.

1. Describe your dizziness (check all that apply):
   - ☐ Spinning sensation
   - ☐ Light headaches
   - ☐ Swimmy-headed sensation
   - ☐ Imbalance
   - ☐ Other ______________________________________________

2. If you checked spinning sensation, do you feel like:
   ☐ You are spinning. ☐ The room is spinning.

3. Approximately when was the first onset of your dizziness?

4. What were you doing when your dizziness first began?

5. How long did your first episode of dizziness last?

_______ Seconds _______ Minutes _______ Hours _______ Days

6. Is your dizziness constant (no cessation since onset, even when sitting still or lying down)? ☐ Yes *(skip to question 13)* ☐ No

7. If no, have you had subsequent episodes? ☐ Yes *(skip to question 13)* ☐ No
   - ☐ A few more isolated incidents _______
   - ☐ I'm experiencing episodes frequently (several a week) _______
   - ☐ I'm having daily episodes _______
   - ☐ Other______________________________________

8. If daily, how many episodes do you have a day, on average? ______________________________________

9. And how long are your episodes lasting now?

_______ Seconds _______ Minutes _______ Hours _______ Days

10. Are you completely free of dizziness between your episodes? ☐ Yes ☐ No

11. Do you have any warning your dizziness is about to start? ☐ Yes ☐ No

    If yes, please explain: ______________________________________________

12. Is your dizziness provoked by head/body movements? ☐ Yes ☐ No

If yes, please check all that apply

- ☐ Bending forward
- ☐ Returning upright
- ☐ Looking upward
- ☐ Looking downward
- ☐ Turning from side to side
- ☐ Looking from side to side
- ☐ Turning over in bed
- ☐ Lying down in bed
- ☐ Getting out of bed
- ☐ Getting out of a chair
- ☐ Walking at the mall/grocery store
- ☐ When looking at a computer screen
- ☐ Whenever I move in any direction
- ☐ I am dizzy with or without motion
- ☐ Other ______________________________

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13. Please check all that apply.

- ☐ I have migraine headaches.
  How often? ______________________________
- ☐ I have diabetes.
  Is it well-regulated? ______________________________
- ☐ I have high blood pressure.
  Is it well-regulated? ______________________________
- ☐ I have had injuries to my head.
  When and how? ______________________________
- ☐ I have blacked out and/or lost consciousness.
- ☐ I have fallen.
  How many times? ______________________________
- ☐ I veer to the right or left when I walk.
- ☐ I lose my balance when walking.
- ☐ I have pressure in my head.
- ☐ I have pressure in my ears.
  Both ears? ______________________________
- ☐ I have difficulty hearing.
  Both ears? ______________________________
- ☐ I have a hearing loss that started when I became dizzy.
  Both ears? ______________________________
- ☐ My hearing changes when I am dizzy.
  Both ears? ______________________________
- ☐ I have tinnitus (ringing, roaring, hissing, pulsing, popping sounds) in my ears.
  Both ears? ______________________________
  Is it constant or intermittent? ______________________________
- ☐ I have a tinnitus that changes when I am dizzy.
- ☐ I have numbness in my face, arms and/or legs.
- ☐ I have weakness in my arms and/or legs.
- ☐ I have bouts of confusion (not knowing who I am, where I am) and/or difficulty talking.
- ☐ I see glittering or flashing lights in my visual field.
- ☐ I have bouts of double vision, blurred vision and/or blindness.
- ☐ I have a history of motion sickness.
- ☐ My dizziness makes me nauseous/vomit.
- ☐ I have issues with my hips, knees and/or ankles (surgeries, injuries, arthritis, etc.).
- ☐ I have issues with my neck and/or back (surgeries, injuries, arthritis, etc.).

14. Is there anything that is happening that you think is relevant or connected to your dizziness that has not been addressed on this intake form? ______________________________

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**What should I expect at my VNG appointment?**

VNG is an abbreviation for videonystagmography. It is a test a physician requests for patients with a history of dizziness, vertigo, imbalance or falls. VNG testing is designed to observe the function of your central nervous system, as it relates to balance, and the vestibular portion of your inner ear. This is because abnormalities in these areas can cause dizziness and imbalance.

During the two-hour evaluation, we will perform a hearing test, gather a case history and then perform different tests/tasks that will assess the sensorimotor, visual and vestibular portions of your balance system. During a portion of this evaluation, you will be wearing goggles with infrared cameras, and during some tests, we will place a cover over the goggles. We will also perform a test that will use air to stimulate the vestibular system, and you may feel like you are floating or slightly moving. Rest assured, we are creating this feeling with the air, and it will dissipate within minutes.

After your evaluation, we will collect and analyze your results and generate a report that will be used to recommend treatment or further testing. A copy of this report will be sent to your referring/primary physician after your follow-up appointment with your ENT physician, which will be scheduled immediately after your VNG assessment.