Physician's Choice Hearing & Dizziness Center

Jeffrey Clark, AuD, CCC-A, F-AAA
Doctor of Audiology

Scott A. Sims, AuD., CCC-A, F-AAA
Doctor of Audiology

3450 East Fletcher Ave, STE 240
Tampa, FL 33613
(813)558-1477

4040 Upper Creek Dr, STE 103
Sun City Center, FL 33573
(813)558-1477

ENG Instructions

You have been scheduled for an ENG on ____________________ at ____________

The ENG is a test designed to give your physician information about the source of your dizziness or unsteadiness. The test requires about ninety (90) minutes to two hours to complete. Although many people experience some dizziness during the test, the dizziness is of short duration and should subside by completion of the test.

You may bring someone to drive you home if you feel that it is necessary.

IN ORDER TO ACHIEVE THE BEST TEST RESULTS, THE PATIENT SHOULD CAREFULLY FOLLOW THESE INSTRUCTIONS:

1. *Remove contact lenses before the exam.*
2. *Face should be washed thoroughly (creams, lotions and makeup should not be used). ABSOLUTELY NO EYE MAKEUP SHOULD BE WORN.*
3. *No solid foods or milk for four hours before the test, unless you are a diabetic.*
4. *No coffee, tea or cola after midnight on the day of the test.*
5. *No alcohol beverages or liquid medication containing alcohol for two days before testing.*
6. *Do not take any medications to suppress dizziness or vertigo after midnight on the day of the test.*
7. *Please bring us a copy of all medication you are currently taking.*

PLEASE MAKE US AWARE OF ALL CURRENT MEDICATION

Patient Name: ______________________________

Date of Birth: ______________________________

Primary Care Physician: ______________________________

What is the primary reason for your visit? ______________________________________ _

DIZZINESS QUESTIONAIRE

CHARACTERISTICS OF DIZZINESS

Is your dizziness associated with any of the following sensations? Please read the entire list first. Then circle "YES" or "NO" to describe your feelings most accurately.

YES NO 1. Light headedness or swimming sensation in the head.

YES NO 2. Blacking out or loss of consciousness.

YES NO 3. Tendency to fall.

YES NO 4. Objects spinning or turning around you.

YES NO 5. Sensation that you are turning or spinning inside with outside objects remaining stationary.

YES NO 6. Loss of balance when walking in the light: Veering to the Right? Left?

YES NO 7. Loss of balance when walking in the dark: Veering to the Right? Left?

YES NO 8. Headache.

YES NO 9. Nausea.

YES NO 10. Vomiting.

YES NO 11. Pressure in the head.

YES NO 12. Tingling in the fingers or toes?

YES NO 13. Tingling around the mouth?

TIME COARSE AND AGGRAVATING FACTORS

1. When did your dizziness first occur? ______________________________
2. How often do you become dizzy? ______________________________
3. If in attacks, how long does an attack last? ______________________________
4. Do you have any warning that the attack is about to start? YES NO
   If so, How? ______________________________
5. Do they occur at any particular time of the day or night? YES NO
   When? ______________________________
6. Are you completely free of dizziness between attacks? YES NO
7. Does a change of position make you dizzy? YES NO
   Which movements? ______________________________
8. Do you become dizzy when rolling over in bed? YES NO
   To the right? To the Left?
9. Do you know of any possible cause for your dizziness? YES NO
   What? ______________________________
10. Do you know of anything that will:
    a) Stop your dizziness or make it better? ______________________________
    b) Make your dizziness worse? ______________________________
11. Do you become dizzy when you bend your head: Forward? Backward?
12. Do you become dizzy when you cough? YES NO
13. Do you become dizzy when you sneeze? YES NO
14. Do you become dizzy when you make a bowel movement? YES NO
15. Can any of the following make your dizziness worse or precipitate an attack?
    - Fatigue?
    - Exertion?
    - Hunger?
    - Menstrual period?
    - Stress?
    - Emotional upset?
    - Alcohol?
16. Do you have allergies? What? ______________________________

    ____

    ____

PAST MEDICAL HISTORY

1. Do you have a history of ear aches or ear infections as a child? YES NO

   How often? ______________________________

2. Did you ever injure your head? YES NO

   When? ______________________________

3. Were you ever unconscious? YES NO

   When? ______________________________

4. Do you take any medications regularly? YES NO

   Please list: ______________________________

5. Have you taken medications in the past for dizziness? YES NO

   What? ______________________________

6. Do you use tobacco in any form? YES NO

   What kind? ______________________________

7. Does caffeine affect your dizziness? YES NO

   How? ______________________________

8. Does alcohol affect your dizziness? YES NO

   How? ______________________________

9. Do you have a past medical history of:

Condition		
Diabetes	YES	NO
Heart Disease	YES	NO
High blood pressure	YES	NO
Kidney Disease	YES	NO
Thyroid Disease	YES	NO
Migraine Headaches	YES	NO

10. Do you have a family history of:

Condition		
Ear Disease	YES	NO
Neurologic Disease	YES	NO
Migraine Headaches	YES	NO

11. Have you had any surgeries since birth? YES NO

   If yes, explain: ______________________________

   ____

   ____

ASSOCIATED OTOLOGIC SYMPTOMS

Do you have any of the following symptoms? Please circle "YES" or "NO" and circle the ear involved, if appropriate.

1. Dizziness. Describe: ____________________
2. Difficulty hearing? YES NO Both Ears Right Left
3. Does your hearing change with dizziness?
   If so how? ____________________
4. Do you have noise in your ears? YES NO Both Ears Right Left
5. Does noise change with dizziness? YES NO
   If so how? ____________________
6. Do you have fullness or stuffiness in your ears? YES NO Both Ears Right Left
7. Do you have pain in your ears? YES NO Both Ears Right Left
8. Do you have discharge from your ears? YES NO Both Ears Right Left

ASSOCIATED NEUROLOGIC SYMPTOMS

Have you experienced any of the following symptoms? Please circle "YES" or "NO" and circle if "Constant" or "In Episodes".

1. Double Vision? Yes No Constant In Episodes
2. Blurred Vision? Yes No Constant In Episodes
3. Blindness? Yes No Constant In Episodes
4. Numbness of the face or extremities? Yes No Constant In Episodes
5. Weakness in the arms of legs? Yes No Constant In Episodes
6. Clumsiness of the arms or legs? Yes No Constant In Episodes
7. Confusion or loss of consciousness? Yes No Constant In Episodes
8. Difficulty with speech? Yes No Constant In Episodes
9. Difficulty with swallowing? Yes No Constant In Episodes
10. Pain in neck or shoulders Yes No Constant In Episodes