

Patient Questionnaire

1. **Describe your symptoms:** Spinning Rocking Off balance Lightheaded Other

Describe other: _____

When did they begin? _____

How frequent do they occur? _____ times a week, _____ times a month, or _____ times a year

How long do they last? _____ seconds, _____ hours, or _____ days

When was the last episode? _____

2. Does anything trigger your symptoms?

- turning in bed getting out of bed quickly head movements
 bending over standing up quickly eye movements

Other: _____

3. Do you have any other associated symptoms or conditions?

- Motion Sickness Migraine headaches Blood pressure (*High or Low*)
 Hearing loss (*L or R*) Stroke Diabetes
 Ringing in ears (*L or R*) Blurred vision Vascular disease
 Fullness in ears (*L or R*) Slurred speech Neck pain / arthritis
 Sinus problems Numbness anywhere TMJ syndrome

Other: _____

4. Do you notice if you veer to left or right while walking? Left Right

5. Have you recently taken a cruise or been on a boat? Yes No

If yes: How long ago? _____

6. Have you ever fallen due to your dizziness? Yes No

7. Have you ever had a head injury? Yes No

If yes, describe: _____

8. Have you had a recent change in your vision? Yes No

9. Have you undergone or scheduled for any other tests? Yes No

Describe: _____

Consent to Procedures

Your physician has requested that you have a diagnostic test called a Video Nystagmography, a VNG. A VNG technician or licensed physical therapist will perform the VNG test in the office and will explain each part of the test as it is administered. While unlikely, the following risks and possible side effects involved include but are not limited to the following: fatigue, dizziness, nausea, vomiting, imbalance, vertigo, headache, redness on the face from wearing goggles, eye fatigue and eye dryness.

I permit the VNG staff to perform the necessary procedures for my diagnostic test.

Signature of Patient/ Patient's Agent or Representative

Date

Signature of Witness from BDMC/BNPT Staff

Date