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Ear, Nose, Throat • Head and Neck Surgery • Otology
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Information for Electronystagmography (ENG) Testing

ENG is a test of balance function and eye coordination. It helps determine the condition of the balance portion of the inner ear. We are looking to determine if your dizziness is located in the central nervous system (brain) or the peripheral nervous system (ear and balance organ).

What to expect the day of your testing

The principle of ENG testing is similar to an EKG; electrodes are placed on the forehead and around the eyes. Because a good contact is needed for recordings, we ask that you refrain from wearing any makeup or lotion on your face the day of testing.

During the test you will follow a light as it moves across a light bar with your eyes, so please bring any corrective lenses with you if you wear them. You will be put into different positions on your back and side to measure any dizziness you may be having, so please notify your physician and audiologist if you have any back problems that may be aggravated by this portion of the test. Lastly, warm and cool air will be put into your ears. These stimuli will cause dizziness as balance receptors within the ears are being stimulated. This reaction is recorded and studied by the audiologist and physician. This portion of the test will take about 45 minutes. You may undergo further testing which can require a total of 1.5 to 2 hours of your time.

Results will be analyzed and you will go over them with your physician. Results will also be sent to your referring physician.

Cancellation Policy

Please be prepared to spend about 1.5-2 hours of time in our office on the day of your audiologic and balance testing. This time slot has been blocked off for you so that we can concentrate on your comfort and ensure that test accuracy is maintained. If you fail to appear for your appointment, the time cannot be utilized for other patients.

In the event that you are unable to keep your appointment, please be kind enough to give us at least 48 hours notice so that we may allow someone else to be tested during this period. There will be a $25 fee appended to your statement for cancellation with less than 48 hours notice or “no shows”.

I have read and understand the above statement.

Patient Signature:_____Date:_____

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Instructions To Patients for Electronystagmography (ENG) Testing

Certain substances can influence the body's response to this test, giving an inaccurate or false result. Therefore, please refrain from taking the following medications for 48 Hours prior to the test:

ALL Decongestants: This includes over the counter and prescription medications

Anti-vertigo medicine: Antivert, Ruvert, Transderm scop, etc.

Anti-nausea medicine: Dramamine, Compazine, Bonine, Marezine, Phenergan, Thorazine, Vontrol, Tigan, Transderm scopolamine, etc.

Anti-anxiety: Valium, Librium, Atarax, Vistrarjl, Equanil, Serax, Etrafon, Elavil, Tranxene, Xanax, Restoril, etc.

Sedatives: Rozarem, Ativan, Ambien, Nembuta!, Seconal, Dalmene, Butisol, Halcyon, Restoril, or any sleeping pills

Narcotics and Barbiturates: Phenobarbital, Codeine, Demerol, Dilaudid, Percodan, Phenaphen, Percocet, Darvon, Tylenol #3, Percocet, etc.

Antihistamines: Claritin, Zyrec, Allegra, Dimetapp, Benadryl, Drixoral, Ornade, Actifed, Sudafed, teldrin, Triaminic, Novafed A, any over the counter and prescribed cold meds.

Antidepressants: Desyrel, Effexor, Retneron, Serzone, Wellbutrin, Nardil, Paxil, Parnate, Prozac, Zoloft, Ludiomil, Adapin, Asendin, Limbitrol, Norpramin, Pamelor, Sinequan, Tofranil, Vivactil, etc.

Alcohol in any quantity: Including beer, wine, and cough medicines with alcohol in them

No caffeine 24 hours before testing

No alcohol 48 hours before testing.

Do not eat or drink anything three (3) hours before testing

Do not smoke for three (3) hours before testing

Women should not wear face make-up

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DIZZINESS QUESTIONNAIRE

Patient Name**:** Date**:**

You have indicated you have vertigo, imbalance or dizziness problems. Answer the following questions by circling the appropriate bold response or answering in the blank space provided.

1. My first dizzy attack occurred_____ . My most recent dizzy attack occurred_____.

2. I **can** / **cannot** tell an attack is about to begin. If you can tell, how far ahead can you tell?_____.

3. Which of the following most closely resembles your problem? Mark as many as apply.

- ☐ A whirling or spinning sensation where your surroundings, you, or both move.
- ☐ Imbalance without a sensation of motion that:
  - ☐ Causes a rocking sensation.
  - ☐ Makes you feel like you veer or are pushed to one side.
  - ☐ Makes you feel like you need extra support.
- ☐ A sense of lightheadedness, giddiness, head swimming, floating.
- ☐ None of the above, more like _____ .

4. I have dizziness **all of the time** / **some of the time** / **once in a while**. Symptoms are **constant** / **fluctuate**.

5. I **have** / **do not have** isolated attacks of vertigo that come _____ times a **week** / **month** / **year**.

6. When attacks occur, the sensation of motion lasts on the average _____ **minutes** / **hours** / **days**. It takes _____ **minutes** / **hours** / **days** for me to completely regain my balance after the motion ceases.

7. When my dizziness occurs, I also experience: (*please circle any that apply*)

Ear Ringing	Ear Fullness	Ear Pressure	Hearing Changes	Sound Distortion
Headache	Visual Changes	Ear Pain	Darkening Vision	Numbness/Tingling
Ear Discharge	Nausea	Vomiting	Problem Working	Difficulty Walking
Falling	Unconsciousness	Other:		

8. What triggers dizziness:_____ .

9. What makes it worse:_____ .

10. What makes it better:_____ .

11. My dizziness **seems** / **does not seem** to be worse at a particular time of year.

12. Certain foods **do** / **do not** trigger or exacerbate my symptoms.

13. Number of physician's seen for your dizzy problems:_____

14. Please circle the following specialties you have seen in the past: Family Physician Neurology ENT Specialist Neurotologist Opthalmologist Psychiatrist

Please give additional information about any of the following tests that you have had

Test Type	**Date and Location**	**Test Type**	**Date and Location**
CT Scan		Audiogram	
MRI Scan		ENG	
Ultrasound		ABR	
Blood Tests		EcoG	
Balance Testing		Other:	

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