REVISED 2025

SPACE COAST HEARING & BALANCE

1344 S Apollo Blvd Suite 301
Melbourne, Florida 32901

*Office: 321-309-2806 / Fax: 321-308-4020*

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## Electronystagmography (ENG) Instruction Sheet

You have been scheduled to have specialized testing to determine the cause of your symptoms. This information is necessary for us to reach a diagnosis and prescribe the proper course of treatment for you.

Electronystagmography (ENG) testing is done to determine the condition of the balance portion of the inner ear. It helps with locating the problem area in dizziness related conditions.

*Time required for this evaluation is 2 hours*

You may experience dizziness after this test:
Please arrange to have someone drive you home upon test completion.

Certain substances can influence the body's response to this test, resulting in a futile or false result.

***Please do not take any of the following 48 hours prior to the test:***

**Anti-Nausea Medications:** Dramamine, Compazine, Bonine, Marezine, Thorazine, Reglan, etc.

**Anti-Vertigo Medications:** Anti-vert, Meclizine, etc.

**Tranquilizers / Antidepressants:** Diazepam, Valium, Xanax, Zoloft, etc.

**if antidepressant(s) taken for more than 1 year do NOT discontinue**

**Sedatives:** Rozerem, Ambien, Lunesta, or any other sleeping pills.

**Narcotics / Barbiturates:** Codeine, Percocets, Demerol, Florcet, etc.

**Anti-histamines**: Benadryl, NyQuil, Robitussen, or any other over the counter cold remedy.

**Alcohol in ANY quantity:** Beer, wine, or cough medicines containing alcohol.

**Any types of muscle relaxers**

Do not use make-up or lotions of the face on test date.

Please fill out the attached questionnaire and **bring it with you** on the day of your exam.

APPOINTMENT DATE:_____/_____/_____ TIME:_____

RESULTS DATE:_____/_____/_____ TIME:_____

SIGNATURE:_____ DATE: _____

** The office visit for this test may not be covered by your insurance company.
If it is a non-covered service, a $75 office visit charge will apply.**

**Please be on time.**

*Due to the length of the exam, if you are more than 10 minutes late your appointment will be canceled and the $100 No Show / Late fee will apply.*

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NAME:_____ DOB:_____/_____/_____

Please answer all questions to the best of your ability:

**1. "Dizziness" can be used to describe different types of symptoms. Mark how would you describe your symptoms:**

___ Room Spinning ___ General Imbalance ___ Swimming Sensation ___ Lightheadedness

___ Fainting ___ Turning Sensation ___ Blurring Vision ___ Fatigue

___ Nausea / Vomiting ___ Swaying / Falling ___ Head / Ear Pressure ___ Headache / Migraine

A. When did these symptoms first occur? _____

B. How often do the symptoms happen? (Circle): DAILY WEEKLY MONTHLY CONSTANT

C. How long do the symptoms last? (Circle):

SECONDS MINUTES HOURS DAYS WEEKS CONSTANT

2. YES or NO

___ ___ Do you have any warning that the dizziness is starting? (i.e aura/anxiety)
___ ___ Does your dizziness only occur in certain positions?
___ ___ Do you have a history of head, neck or back trauma / surgery? Which _____
___ ___ Does your dizziness occur with overexertion or exercise?
___ ___ Do you have memory difficulties?
___ ___ Do you have any numbness in the face or extremities? _____
___ ___ Do you have any eye or vision problems? _____
___ ___ Does anything provoke or worsen your dizziness? _____
___ ___ Does anything make your dizziness better/resolve? _____
___ ___ Do you take any medications regularly? _____
___ ___ Do you use tobacco and/or alcohol regularly? Which_____
___ ___ Do you have trouble speaking or swallowing? Which_____
___ ___ Do you have difficulty hearing and/or communicating?
__ Right Ear __ Left Ear __ Both
___ ___ Do you have noise (i.e ringing/buzzing/humming) in your ears?
__ Right Ear __ Left Ear __ Both
___ ___ Do you have any pain or pressure in your ears?
__ Right Ear __ Left Ear __ Both
___ ___ Have you ever tested positive for COVID-19? Most recent positive test: (MM/YY) _____

**Are you currently OR have you ever been treated for any of the following conditions? (Circle):**

DIABETES HIGH BLOOD PRESSURE PYSCHIATRIC CONDITONS AUTOIMMUNE DISORDER

PARKINSONS HEART DISEASE SEIZURES / EPLIEPSY CANCER

STROKE CHIARI MALFORMATION SHINGLES MENIERE'S DISEASE

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# ELECTRONYSTAGMOGRAPHY (ENG) CONSENT FORM

The ENG test is used to assess and detect disorders of the peripheral vestibular system (the portion of the inner ear that interprets balance and spatial orientation) as well as the nerves that connect the vestibular system to the brain and muscles of the eyes.

The test may be performed if an individual is currently experiencing unexplained dizziness, vertigo, hearing loss, aural fullness, or unsteadiness. Additional conditions in which the ENG may be performed are including but not limited to Benign Paroxysmal Positional Vertigo (BPPV), acoustic neuroma, labyrinthitis, and Meniere's Disease. There may be other reasons a physician would recommend an ENG.

Your physician has determined that this test will be beneficial to uncovering the cause of your symptoms.

## RISKS OF THE PROCEDURE

- ENG testing is associated with minimal risks. Some people may experience dizziness or nausea during/following the test.
- Back or neck problems may be aggravated by rapid changes in position required for this test.
    - Please discuss this with your Physician and/or Audiologist prior to beginning the test.
- The air caloric test may produce mild discomfort.
- There may be additional risks depending on your specific medical condition(s).
    - Be sure to discuss any concerns with your physician prior to the procedure

**By signing this consent form, I acknowledge the receipt and understanding of the ENG testing and any possible risks. The answers and additional information provided to me are satisfactory.**

_____ Patient Signature _____ Date

_____ (Office Staff) Witness _____ Date