MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Light-headedness or feeling about to faint

Structured history, interpretation & clinical review

Symptom 33 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Light-headedness or near-faint is characterized by posture, exertion, prodrome, cardiac clues, hydration, medication, and actual loss of consciousness.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Light-headedness or feeling about to faint

1A. Immediate safety screen

Is there chest pain, severe breathlessness, palpitations with collapse, or collapse during exertion?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is there new focal weakness, severe headache, confusion, or difficulty speaking?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is there black or bloody stool, heavy bleeding, severe abdominal pain, or pregnancy with collapse?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now.

Did collapse cause significant injury, or is the person still confused or unresponsive?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

What is the relation to standing or exertion?

☐ Soon after standing ☐ During or immediately after exertion ☐ After prolonged standing, heat, pain, or fear ☐ No clear posture/exertion link

Which symptoms precede it?

☐ Tunnel/dim vision, warmth, nausea, or sweating ☐ Palpitations or chest discomfort ☐ Focal neurological symptoms ☐ No warning

Has there been actual loss of consciousness?

☐ Yes ☐ No, only near-faint ☐ Not sure

Is there bleeding, dehydration, pregnancy, heart disease, or a new blood-pressure medicine?

☐ Yes ☐ No known factor ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Standing-related orthostatic pattern

What is the relation to standing or exertion? Soon after standing
Which symptoms precede it? Tunnel/dim vision, warmth, nausea, or sweating

Prompt clinical review pattern — Promptly

Standing-triggered light-headedness with visual dimming follows orthostatic vital-sign and autonomic assessment.

Differential to review:

- Orthostatic hypotension or autonomic dysfunction
- Neurological, metabolic, medication, or anemia-related symptoms

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 2: Classic reflex near-syncope pattern

What is the relation to standing or exertion? After prolonged standing, heat, pain, or fear
Which symptoms precede it? Tunnel/dim vision, warmth, nausea, or sweating

Prompt clinical review pattern — Promptly

A situational trigger with a classic prodrome supports reflex syncope/near-syncope after cardiac screening.

Differential to review:

- Reflex syncope or situational near-syncope

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 3: Exertional or cardiac-pattern symptoms

What is the relation to standing or exertion? During or immediately after exertion
Which symptoms precede it? Palpitations or chest discomfort / No warning

Emergency warning pattern — Now

Exertional symptoms or palpitations without a classic prodrome require urgent cardiac assessment.

Differential to review:

- Cardiac arrhythmia or structural cardiopulmonary disease

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 4: Actual transient loss of consciousness

Has there been actual loss of consciousness? Yes

Urgent assessment pattern — Same day

Actual loss of consciousness requires a dedicated syncope/collapse assessment, not only a dizziness label.

Differential to review:

- Reflex syncope or situational near-syncope
- Cardiac arrhythmia or structural cardiopulmonary disease
- Neurological, metabolic, medication, or anemia-related symptoms

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Orthostatic hypotension or autonomic dysfunction

Discriminating features: Symptoms after standing with measured postural BP/HR change or autonomic clues.

Logical investigations: Supine/standing vital signs, hydration and medication review, targeted blood count/metabolic testing, and autonomic evaluation when indicated.

3.2 Reflex syncope or situational near-syncope

Discriminating features: Heat, pain, fear, or prolonged standing with a classic vasovagal prodrome.

Logical investigations: History, examination, ECG when syncope occurs, and assessment of injury and recurrence.

3.3 Cardiac arrhythmia or structural cardiopulmonary disease

Discriminating features: Exertional symptoms, palpitations, chest discomfort, no prodrome, or known heart disease.

Logical investigations: Prompt ECG and cardiovascular assessment; exertional collapse or associated chest symptoms is an emergency.

3.4 Neurological, metabolic, medication, or anemia-related symptoms

Discriminating features: Focal neurological symptoms, hypoglycemia, anemia, dehydration, or drug effects can mimic presyncope.

Logical investigations: Targeted glucose/blood count/metabolic and neurological assessment based on the actual phenotype.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2010, updated 2023). *Transient loss of consciousness (“blackouts”) in over 16s (CG109)*. https://www.nice.org.uk/guidance/cg109

2. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127

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