MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Loss of part of the visual field

Structured history, interpretation & clinical review

Symptom 45 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

A missing visual field is localized by one/both eyes, congruent same-sided loss, onset, bumping behavior, retinal warnings, and associated neurological signs.

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 Loss of part of the visual field

1A. Immediate safety screen

Is there sudden visual loss, a curtain or missing field, or a new large shower of floaters or flashes?

☐ No ☐ Yes ☐ Not sure

If Yes: Contact an emergency eye service or emergency department now.

Is there a painful red eye, halos, vomiting, marked light sensitivity, or pain with eye movement?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek same-day emergency eye assessment; sudden visual loss requires emergency care now.

Is there new double vision with weakness, severe headache, confusion, imbalance, or difficulty speaking?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record onset or last-known-well time.

Is there eye protrusion, fever, eyelid swelling, new inability to move the eye, or recent eye trauma?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye/orbital 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

Which field pattern is reported?

☐ One eye only ☐ The same left or right side in both eyes ☐ Outer vision in both eyes ☐ Central blind or missing area

Is the field defect constant or intermittent?

☐ Constant ☐ Separate transient episodes ☐ Gradually enlarging ☐ Not sure

Is the person bumping into objects or missing people/text on one side?

☐ Yes ☐ No ☐ Not sure

Are there flashes/floaters, eye pain, headache, weakness, or reading/language difficulty?

☐ Flashes/floaters or curtain ☐ Weakness, language, or coordination symptoms ☐ Headache only ☐ None

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: Acute homonymous field-loss pathway

Which field pattern is reported? The same left or right side in both eyes
How did the symptom begin? Suddenly, over seconds or minutes / Over hours to days

Emergency warning pattern — Now

Acute same-sided field loss in both eyes requires emergency cerebral vascular assessment.

Differential to review:

- Occipital, optic-radiation, or other retrochiasmal lesion

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

Pattern 2: Monocular or retinal-warning field loss

Which field pattern is reported? One eye only
Are there flashes/floaters, eye pain, headache, weakness, or reading/language difficulty? Flashes/floaters or curtain

Emergency warning pattern — Now

A monocular field defect with retinal warnings needs emergency eye assessment.

Differential to review:

- Retinal detachment, vascular occlusion, glaucoma, or retinal degeneration

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

Pattern 3: Progressive peripheral or chiasmal pattern

Which field pattern is reported? Outer vision in both eyes
Is the field defect constant or intermittent? Gradually enlarging

Prompt clinical review pattern — Promptly

Progressive bilateral peripheral loss requires formal ocular, optic-nerve, and chiasmal evaluation.

Differential to review:

- Retinal detachment, vascular occlusion, glaucoma, or retinal degeneration
- Optic nerve/chiasm disorder

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

Pattern 4: Transient field episodes

Is the field defect constant or intermittent? Separate transient episodes

Urgent assessment pattern — Same day

Transient field loss requires prompt separation of retinal/cerebral ischemia from migraine or seizure phenomena.

Differential to review:

- Occipital, optic-radiation, or other retrochiasmal lesion
- Migraine aura, transient ischemia, or inattention/neglect

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.

Urgent assessment pattern — Same day

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

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 Occipital, optic-radiation, or other retrochiasmal lesion

Discriminating features: Same-sided field loss in both eyes, reading/spatial symptoms, or focal neurological associations.

Logical investigations: Urgent formal fields and brain/vascular imaging for acute onset; neurological examination for associated deficits.

3.2 Retinal detachment, vascular occlusion, glaucoma, or retinal degeneration

Discriminating features: Monocular field loss, curtain/flashes, progressive peripheral loss, or ocular examination findings.

Logical investigations: Urgent dilated retinal and ophthalmic assessment, pressure and visual-field testing according to tempo.

3.3 Optic nerve/chiasm disorder

Discriminating features: Central/monocular nerve-type loss or bitemporal peripheral pattern with pituitary/chiasmal clues.

Logical investigations: Neuro-ophthalmic fields, OCT and targeted MRI/endocrine evaluation as indicated.

3.4 Migraine aura, transient ischemia, or inattention/neglect

Discriminating features: Transient positive/negative phenomena or inconsistent awareness may mimic a fixed field cut.

Logical investigations: Event timing and both-eye testing; stroke evaluation for acute negative symptoms and cognitive/spatial assessment for neglect.

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. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127

2. American Academy of Ophthalmology. (2020). *Preferred Practice Pattern: Comprehensive Adult Medical Eye Evaluation*. https://www.aao.org/preferred-practice-pattern/comprehensive-adult-medical-eye-evaluation-ppp