MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Non-specific dizziness, floating, or “fuzzy-headedness”

Structured history, interpretation & clinical review

Symptom 34 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

Non-specific dizziness is converted into a testable description: vertigo, presyncope, imbalance, visual dependence, medication effect, or altered awareness.

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 Non-specific dizziness, floating, or “fuzzy-headedness”

1A. Immediate safety screen

Is there new face droop, one-sided weakness or numbness, difficulty speaking or understanding, double vision, or severe loss of coordination?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the exact time the person was last known well.

Is there new confusion, reduced consciousness, a seizure, or difficulty awakening?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now. Do not leave the person alone or give food, drink, or medication by mouth.

Is there new severe breathlessness, inability to swallow saliva, blue lips, or rapidly worsening weakness?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now; breathing and swallowing problems can become critical quickly.

Is there sudden loss of vision, a new missing visual field, or a painful red eye?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye or emergency-department 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 description is closest?

☐ Spinning or motion when still ☐ About to faint or visual dimming ☐ Floating, fuzzy, or disconnected ☐ Unsteady rather than dizzy

Are busy visual environments, screens, or standing still prominent triggers?

☐ Busy visual scenes or screens ☐ Standing or walking ☐ No consistent trigger ☐ Not sure

Is there any blankness, confusion, or lost time?

☐ Yes ☐ No ☐ Not sure

Did symptoms follow a medicine, substance, blood-pressure change, or illness?

☐ Yes ☐ No ☐ 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: Visually dependent chronic dizziness

Which description is closest? Floating, fuzzy, or disconnected
Are busy visual environments, screens, or standing still prominent triggers? Busy visual scenes or screens
What is the overall course? One persistent episode / Steadily worsening / Fluctuating or variable

Structured clinical review pattern — Routine review

Chronic floating symptoms amplified by visual motion fit a visually dependent/PPPD assessment pattern after vestibular screening.

Differential to review:

- Persistent postural-perceptual or visually triggered dizziness

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Pattern 2: Presyncopal or standing pattern

Which description is closest? About to faint or visual dimming
Are busy visual environments, screens, or standing still prominent triggers? Standing or walking

Prompt clinical review pattern — Promptly

Near-faint and standing symptoms redirect to orthostatic and cardiovascular assessment.

Differential to review:

- Orthostatic, cardiovascular, metabolic, or medication-related dizziness

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

Pattern 3: Vestibular or imbalance pattern

Which description is closest? Spinning or motion when still / Unsteady rather than dizzy

Prompt clinical review pattern — Promptly

Motion illusion or imbalance requires a dedicated vestibular/cerebellar pathway.

Differential to review:

- Vestibular or cerebellar disorder

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

Pattern 4: Dizziness with altered awareness

Is there any blankness, confusion, or lost time? Yes

Urgent assessment pattern — Same day

Blankness or lost time requires event characterization for seizure, syncope, or another altered-awareness disorder.

Differential to review:

- Epileptic, migraine, anxiety, or dissociative episode

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 Persistent postural-perceptual or visually triggered dizziness

Discriminating features: Chronic floating/unsteadiness amplified by visual motion, often after an initial vestibular event.

Logical investigations: Vestibular/neurological examination and phenotype history; distinguish from active positional or episodic vestibular disease.

3.2 Orthostatic, cardiovascular, metabolic, or medication-related dizziness

Discriminating features: Standing/exertion pattern, presyncopal symptoms, systemic illness, or drug timing.

Logical investigations: Orthostatic vital signs, medication review, ECG/glucose/other tests according to associated clues.

3.3 Vestibular or cerebellar disorder

Discriminating features: True motion illusion or objective imbalance directs vestibular/cerebellar assessment.

Logical investigations: Eye movement, coordination, hearing and gait examination; targeted vestibular testing or imaging when indicated.

3.4 Epileptic, migraine, anxiety, or dissociative episode

Discriminating features: Blankness/lost time, migraine association, or stereotyped episodes require event-level characterization.

Logical investigations: Witness/video history and neurological assessment; EEG only when seizure suspicion is supported, not for nonspecific dizziness alone.

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. Bhattacharyya N, Gubbels SP, Schwartz SR, et al.. (2017). *Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Update)*. https://pubmed.ncbi.nlm.nih.gov/28248609/

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