MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

# Spinning sensation or vertigo

Structured history, interpretation & clinical review

Symptom 32 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

Vertigo is classified by timing and triggers, auditory symptoms, positional behavior, neurological findings, and ability to stand or walk.

**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 Spinning sensation or vertigo

## 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 timing pattern fits best?**

☐ Seconds, triggered by head position ☐ Minutes to hours, recurrent ☐ Continuous for days ☐ Brief nonspecific or highly variable

**What brings on an episode?**

☐ Rolling over, looking up, or lying back ☐ Occurs without a trigger ☐ Headache or migraine-related context ☐ Not sure

**Is there hearing loss, ear fullness, tinnitus, or recent ear infection?**

☐ New hearing change or ear fullness ☐ Tinnitus without hearing change ☐ Recent ear/respiratory infection ☐ No ear symptom

**During the worst episode, can the person stand and walk independently?**

☐ Yes, though uncomfortable ☐ No, severe truncal instability ☐ Not assessed

## 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.

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## Pattern 1: Brief positional vertigo pattern

**Which timing pattern fits best?** Seconds, triggered by head position
**What brings on an episode?** Rolling over, looking up, or lying back
**Is there hearing loss, ear fullness, tinnitus, or recent ear infection?** No ear symptom
**During the worst episode, can the person stand and walk independently?** Yes, though uncomfortable

### Prompt clinical review pattern — Promptly

Brief position-triggered vertigo without reported auditory/neurological warnings fits a BPPV assessment pathway.

**Differential to review:**

- Benign paroxysmal positional vertigo

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

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## Pattern 2: Recurrent spontaneous episodic vertigo

**Which timing pattern fits best?** Minutes to hours, recurrent
**What brings on an episode?** Occurs without a trigger / Headache or migraine-related context

### Prompt clinical review pattern — Promptly

Recurrent spontaneous episodes are separated using auditory and migraine-associated features.

**Differential to review:**

- Vestibular neuritis, labyrinthitis, or Ménière-type disorder
- Vestibular migraine, PPPD, medication, or systemic dizziness

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

## Pattern 3: Continuous acute vestibular syndrome

**Which timing pattern fits best?** Continuous for days
**How did the symptom begin?** Suddenly, over seconds or minutes / Over hours to days

**Urgent assessment pattern — Same day**

Continuous acute vertigo requires same-day peripheral-versus-central assessment.

**Differential to review:**

- Vestibular neuritis, labyrinthitis, or Ménière-type disorder
- Posterior-circulation stroke or central vestibular lesion

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

## Pattern 4: Severe inability to stand or walk

**During the worst episode, can the person stand and walk independently?** No, severe truncal instability
**How did the symptom begin?** Suddenly, over seconds or minutes

**Emergency warning pattern — Now**

Severe truncal instability with sudden vertigo is a central warning pattern.

**Differential to review:**

- Posterior-circulation stroke or central vestibular lesion

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

## 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 Benign paroxysmal positional vertigo

**Discriminating features:** Brief position-triggered episodes without new hearing loss or focal neurological signs.

**Logical investigations:** Positional examination by a trained clinician; neurological reassessment if the history or nystagmus is atypical.

## 3.2 Vestibular neuritis, labyrinthitis, or Ménière-type disorder

**Discriminating features:** Continuous acute vestibular syndrome or recurrent episodes; hearing and ear symptoms separate peripheral disorders.

**Logical investigations:** Focused eye/ear and neurological examination, audiometry, and clinician-directed testing; HINTS only in the appropriate continuous syndrome by trained examiners.

## 3.3 Posterior-circulation stroke or central vestibular lesion

**Discriminating features:** Severe truncal instability, focal neurological signs, new headache/neck pain, or central eye-movement findings.

**Logical investigations:** Emergency stroke/vascular assessment for sudden central warning signs; MRI and vascular imaging as clinically indicated.

## 3.4 Vestibular migraine, PPPD, medication, or systemic dizziness

**Discriminating features:** Recurrent migraine-linked vertigo, chronic visually triggered dizziness, medication effects, or non-vestibular systemic contributors.

**Logical investigations:** Attack diary, medication and migraine review, vestibular/orthostatic examination, and targeted testing based on syndrome.

## 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/