MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Symptoms on standing

Structured history, interpretation & clinical review

Symptom 86 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

Symptoms on standing are documented with posture timing, recovery on lying, exertion, hydration, bleeding, medication, heart-rate symptoms, and associated autonomic or neurological disease.

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 Symptoms on standing

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

When after standing do symptoms begin?

☐ Within three minutes ☐ After prolonged standing ☐ Mainly during exertion ☐ No consistent timing

What happens after lying down?

☐ Prompt improvement ☐ Partial or slow improvement ☐ No clear improvement ☐ Not tried or not sure

Are there palpitations, chest symptoms, sweating, visual dimming, tremulousness, or fainting?

☐ Chest pain, breathlessness, or exertional palpitations ☐ Nausea, warmth, sweating, or visual dimming ☐ Marked palpitations or tremulousness without chest pain ☐ None

Is there dehydration, bleeding, anemia, diabetes, Parkinsonism, neuropathy, or a BP-averting/heart-rate medicine?

☐ Poor intake, vomiting, diarrhea, or bleeding ☐ Diabetes, neuropathy, or Parkinsonism ☐ Relevant medication or dose change ☐ None identified

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: Exertional or cardiac standing symptoms

When after standing do symptoms begin? Mainly during exertion
Are there palpitations, chest symptoms, sweating, visual dimming, tremulousness, or fainting? Chest pain, breathlessness, or exertional palpitations

Emergency warning pattern — Now

Exertional light-headedness with cardiac symptoms requires urgent cardiovascular assessment.

Differential to review:

- Cardiac, neurological, metabolic, or non-orthostatic mimic

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

Pattern 2: Immediate orthostatic pattern

When after standing do symptoms begin? Within three minutes
What happens after lying down? Prompt improvement

Prompt clinical review pattern — Promptly

Immediate standing symptoms relieved by lying support an orthostatic BP or intolerance assessment.

Differential to review:

- Orthostatic hypotension or hypovolemia
- Postural tachycardia or another orthostatic-intolerance disorder

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

Pattern 3: Reflex presyncope pattern

When after standing do symptoms begin? After prolonged standing
Are there palpitations, chest symptoms, sweating, visual dimming, tremulousness, or fainting? Nausea, warmth, sweating, or visual dimming
What happens after lying down? Prompt improvement

Prompt clinical review pattern — Promptly

Prolonged standing with a classic prodrome and lying relief supports reflex presyncope after ECG and risk review.

Differential to review:

- Reflex syncope or situational presyncope

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

Pattern 4: Volume, medication, or autonomic contributor

Is there dehydration, bleeding, anemia, diabetes, Parkinsonism, neuropathy, or a BP-averting/heart-rate medicine? Poor intake, vomiting, diarrhea, or bleeding / Relevant medication or dose change / Diabetes, neuropathy, or Parkinsonism

Prompt clinical review pattern — Promptly

Volume, drug, diabetes, neuropathy, or Parkinsonism clues direct the orthostatic evaluation.

Differential to review:

- Orthostatic hypotension or hypovolemia
- Postural tachycardia or another orthostatic-intolerance disorder

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

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 hypovolemia

Discriminating features: Immediate standing symptoms with postural BP fall, volume loss, bleeding, or relevant medication.

Logical investigations: Supine/standing BP and heart rate, hydration/bleeding assessment, medication review, and targeted laboratory tests.

3.2 Reflex syncope or situational presyncope

Discriminating features: Prolonged upright posture with nausea, warmth, sweating, visual dimming, and recovery on lying.

Logical investigations: History, examination and ECG; assess for injury and atypical cardiac features.

3.3 Postural tachycardia or another orthostatic-intolerance disorder

Discriminating features: Chronic standing intolerance with marked heart-rate rise or adrenergic symptoms without diagnostic BP fall.

Logical investigations: Standardized orthostatic vitals, ECG, and clinician-directed autonomic assessment after alternative causes are considered.

3.4 Cardiac, neurological, metabolic, or non-orthostatic mimic

Discriminating features: Exertional symptoms, chest findings, arrhythmia, focal signs, glucose disturbance, or poor positional relationship.

Logical investigations: Urgent cardiac assessment for exertional/chest features; otherwise targeted metabolic and neurological evaluation.

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

Madison Neurology LLC — Neurology Symptom Guide
Symptoms on standing — including light-headedness, weakness, visual dimming, or fainting
Educational reference only. Not for clinical use. Treatment is outside the scope of this workbook.