MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Transient loss of vision or a transient blackout of vision

Structured history, interpretation & clinical review

Symptom 42 of 94

Clinical educational workbook

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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

Transient visual loss or blackout is classified by one/both eyes, duration, positive versus negative phenomena, gaze/position triggers, retinal and hemispheric associations.

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 Transient loss of vision or a transient blackout of vision

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

How was vision affected?

☐ One eye only, confirmed by covering each eye ☐ Both eyes simultaneously ☐ One side of vision in both eyes ☐ Not sure

How long did it last?

☐ Seconds ☐ Minutes ☐ Up to an hour ☐ Longer or recurrent over days

Was vision lost, or were new positive images seen?

☐ Black/grey/dim vision loss ☐ Flashes, zigzags, or shimmering ☐ Blur rather than complete loss ☐ Both positive and negative features

Was there standing, exertion, headache, neck movement, or another trigger?

☐ Standing or blood-pressure context ☐ Headache or migraine context ☐ Neck movement, exertion, or vascular risk ☐ No clear trigger

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: Transient monocular blackout

How was vision affected? One eye only, confirmed by covering each eye
Was vision lost, or were new positive images seen? Black/grey/dim vision loss
How long did it last? Seconds / Minutes / Up to an hour

Emergency warning pattern — Now

Transient monocular blackout requires urgent retinal and cerebrovascular assessment.

Differential to review:

- Retinal or ocular transient ischemia/embolism

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

Pattern 2: Homonymous or neurologically associated transient loss

How was vision affected? One side of vision in both eyes
How did the symptom begin? Suddenly, over seconds or minutes

Emergency warning pattern — Now

Transient same-sided field loss in both eyes follows a cerebral vascular pathway.

Differential to review:

- Cerebral TIA/stroke or occipital disorder

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

Pattern 3: Migraine-aura-like positive phenomena

Was vision lost, or were new positive images seen? Flashes, zigzags, or shimmering
Was there standing, exertion, headache, neck movement, or another trigger? Headache or migraine context
How long did it last? Minutes / Up to an hour

Prompt clinical review pattern — Promptly

Gradual positive binocular phenomena with migraine context fit an aura assessment after ocular/vascular warnings are screened.

Differential to review:

- Migraine aura or occipital seizure

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

Pattern 4: Standing-related bilateral dimming

How was vision affected? Both eyes simultaneously
Was there standing, exertion, headache, neck movement, or another trigger? Standing or blood-pressure context
Was vision lost, or were new positive images seen? Black/grey/dim vision loss

Prompt clinical review pattern — Promptly

Standing-related bilateral dimming suggests presyncopal or orthostatic visual symptoms.

Differential to review:

- Orthostatic, papilledema-related, or ocular surface/refractive transient blur

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.

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 Retinal or ocular transient ischemia/embolism

Discriminating features: Brief monocular blackout or curtain, especially vascular risk, requires retinal and cerebrovascular assessment.

Logical investigations: Urgent ophthalmic and stroke/vascular evaluation; carotid/cardiac testing is clinician-directed.

3.2 Cerebral TIA/stroke or occipital disorder

Discriminating features: Homonymous field loss or associated weakness, speech, or coordination symptoms.

Logical investigations: Emergency stroke pathway for acute focal neurological symptoms and brain/vascular imaging.

3.3 Migraine aura or occipital seizure

Discriminating features: Positive binocular phenomena developing over minutes suggest aura; very brief stereotyped episodes may raise seizure consideration.

Logical investigations: Detailed timing/laterality history, eye and neurological examination; EEG or imaging only for supported atypical features.

3.4 Orthostatic, papilledema-related, or ocular surface/refractive transient blur

Discriminating features: Standing-related bilateral dimming, brief posture-related obscurations, or surface/refraction fluctuation.

Logical investigations: Orthostatic vitals, optic-disc and ocular examination; pressure-focused assessment if disc swelling or positional obscurations occur.

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