DIZZINESS, LIGHT HEADED
(example – vertigo)

Subjective Data:
Chief complaint: ___________________________
Onset: ___________  ☐ New Onset  ☐ Chronic  ☐ Recurrence

History:
Newly or recently discontinued medication: ☐ Yes  ☐ No  If “Yes” State: ___________________________
Loss of conscious: ☐ Yes  ☐ No  If “Yes” When: ___________________________
Recent head injury: ☐ Yes  ☐ No  If “Yes” When: ___________________________
Recent exposure to sun: ☐ Yes  ☐ No  If “Yes” When: ___________________________
Similar past problem: ☐ Yes  ☐ No  If “Yes” When: ___________________________
History of:  ☐ Hypertension  ☐ Inner ear problems  ☐ Sinus problems  ☐ Seizures  ☐ Diabetes  ☐ Cardiac

Current medication(s): ____________________________________________

Associated symptoms:
☐ Nausea  ☐ Vomiting  ☐ Ringing in ears  ☐ Pain in ears  ☐ Loss of hearing  ☐ Numbness/weakness

Objective Data: (clinically indicated VS)

Tilt Test: BP (sitting) _______ (lying) _______ (standing) _______ Pulse (sitting) _______ (lying) _______ (standing) _______

Resp. _______ Temp. _______ Wt. _______ O2 sats. _______ FSBS: _______

<table>
<thead>
<tr>
<th>Skin Color</th>
<th>Skin</th>
<th>Turgor</th>
<th>Neurological</th>
<th>Ears</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pink</td>
<td>Warm</td>
<td>Normal</td>
<td>Awake</td>
<td>No</td>
<td>Strong</td>
</tr>
<tr>
<td>Pale</td>
<td>Cool</td>
<td>Pale</td>
<td>Alert</td>
<td>No</td>
<td>Regular</td>
</tr>
<tr>
<td>Cyanotic</td>
<td>Dry</td>
<td>Decreased</td>
<td>Oriented X_</td>
<td>No</td>
<td>Weak</td>
</tr>
<tr>
<td>Mottled</td>
<td>Clammy</td>
<td>Confused</td>
<td>Lethargic</td>
<td>No</td>
<td>Thready</td>
</tr>
<tr>
<td>Jaundiced</td>
<td></td>
<td>Comatose</td>
<td>Comatose</td>
<td>No</td>
<td>Irregular</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normal gait</td>
<td>Normal gait</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abnormal gait</td>
<td>Abnormal gait</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pupils equal</td>
<td>No</td>
<td></td>
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<td></td>
<td></td>
<td>Pupils unequal</td>
<td>No</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Pupils constricted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PERRLA</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Follows commands</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unable to follow commands</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF: Health care provider must be called if not on site or if after clinic hours.
☐ Change in dizziness from mild to severe
☐ History of vertigo, over exposure to sun, bleeding
☐ Abnormal ear symptoms
☐ Nausea / vomiting, dehydration
☐ On medication
☐ Neurological deficits: unequal pupils, difficulty walking/abnormal gait, weakness, numbness, facial asymmetry, disorientation

Health Care Provider: ___________ Time Notified: ___________ Orders Received for Treatment: ☐ Yes  ☐ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)
☐ Check in assessment only for health care providers visit.
☐ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
☐ Place in supine position with eyes open have inmate stare straight ahead and place pillow on each side of head.
☐ Antihistamine “Meclizine, (Antivert)” one (1) p.o. 3 times day pending health care provider assessment (This will require an order from the health care provider)
☐ Encourage increase of oral fluids.
☐ Education/Intervention: Instructed to sit when feeling dizzy to avoid injury, methods to decrease sensation of vertigo, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: ____________________________________________

Health Care Provider Signature/Credentials: ____________________________ Date: _______ Time: _______

RN/LPN Signature/Credentials: ____________________________ Date: _______ Time: _______

Inmate Name: ____________________________
(Last, First) DOC #