Taking a Dizziness History:

A Structured Clinical Approach for General Clinicians

Vestibular Medicine for General Clinicians
Topic 1 of 14

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How to Use This Review

This literature review is part of the Vestibular Medicine for General Clinicians series published by the Australian Dizziness Clinics Education Hub. It is written for general practitioners, emergency clinicians, hospital generalists, nursing, and allied health staff who assess and manage patients presenting with dizziness.

The review is designed to be read in a single 20–30 minute sitting, or used as a desktop reference. It is supported by an A4 one-page cheat sheet, short-form clinician videos, and audio episodes that cover the same material.

Callout Box Guide

> □ **Key Point:** *Foundational concepts and summary statements that anchor the core clinical content of each section.*

> □ **Clinical Insight:** *Clinically relevant observations for direct application in assessment and management.*

> □ **Clinical Pearl:** *High-yield memorable clinical points — the take-home messages most likely to change practice.*

> □ **Important:** *Red flags, emergencies, and critical safety points requiring immediate action.*

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I. Why History Is the Most Important Diagnostic Tool in Dizziness

Dizziness is one of the most common reasons for primary care and emergency presentation, accounting for 3–5% of all GP consultations and up to 4% of emergency department visits [1,2]. Despite this volume, diagnostic accuracy for vestibular conditions in non-specialist settings remains poor. Large studies have repeatedly shown that only 20–30% of patients with dizziness receive a correct diagnosis at first contact [3,4].

The most important reason for this diagnostic gap is not a lack of investigations — it is an inadequate history. Studies comparing the diagnostic yield of each clinical step have confirmed that history alone correctly classifies the cause of dizziness in 70–75% of patients, while targeted examination adds a further 10–15% [5]. Imaging, laboratory testing, and formal vestibular function testing contribute meaningfully in only a minority of cases [6].

> □ **Key Point:**
> In dizziness, history is not just a starting point — it is the single most powerful diagnostic tool available. A structured history, done well, outperforms MRI, audiometry, and laboratory tests combined.

The challenge is that traditional history-taking frameworks (site, onset, character, radiation, associated features, timing, exacerbating/relieving factors, severity) were designed for pain. They do not map well onto vestibular symptoms, where the two most diagnostically useful variables — timing and triggers — are often left until last or omitted entirely.

II. Abandoning the "Type of Dizziness" Approach

For decades, clinicians were taught to begin with the question "What do you mean by dizziness?" and to categorise the symptom into four types: vertigo, pre-syncope, disequilibrium, or non-specific lightheadedness. This approach was based on work by Drachman and Hart in 1972 [7].

Multiple subsequent studies have shown that symptom-type categorisation is unreliable. Patients change their description when asked the same question at different times [8], multiple vestibular disorders produce overlapping descriptions [9], and the type of dizziness correlates poorly with the underlying cause [10]. A patient with BPPV may describe "lightheadedness", and a patient with orthostatic hypotension may describe "vertigo".

> □ **Clinical Insight:**
> Asking "do you feel the room spinning?" is one of the least informative questions you can ask. Patients who answer yes may have BPPV, vestibular migraine, Ménière's, vestibular neuritis, vestibular schwannoma, or posterior circulation stroke. Patients who answer no may have any of the same conditions.

The modern evidence-based approach, described by Newman-Toker and colleagues [11], moves away from symptom quality and focuses on timing and triggers. This is the foundation of the TiTrATE framework, now endorsed by the American Academy of Neurology and the 2023 GRACE-3 guidelines [5,12].

III. The TiTrATE Framework

TiTrATE is a structured approach endorsed by the American Academy of Neurology and the Bárány Society consensus documents [12]. It stands for:

- **Ti — Timing.** Is this episodic or continuous? How long do episodes last? When did it start?
- **Tr — Triggers.** What reliably brings the dizziness on?
- **A — Associated symptoms.** Hearing change, neurological symptoms, migraine features, autonomic symptoms.
- **T — Targeted examination.** HINTS for acute vestibular syndrome, Dix-Hallpike for positional vertigo, orthostatic vitals, neurological screen.
- **E — Evaluation.** Imaging, audiometry, or vestibular testing where clinically indicated.

The first two elements — timing and triggers — classify the patient into one of four diagnostic categories, each of which narrows the differential from dozens of possibilities to a handful.

Table 1 — The Four Diagnostic Categories Defined by Timing + Triggers

Category	Pattern	Typical causes
AVS (Acute Vestibular Syndrome)	Continuous vertigo lasting days	Vestibular neuritis, labyrinthitis, posterior circulation stroke
s-EVS (Spontaneous Episodic)	Episodic vertigo, no trigger	Vestibular migraine, Ménière's disease, TIA
t-EVS (Triggered Episodic)	Episodic vertigo, clear trigger	BPPV, orthostatic hypotension, superior canal dehiscence
Chronic	Non-episodic, >3 months	PPPD, bilateral vestibular loss, cerebellar disease

Adapted from Newman-Toker & Edlow [11]. Timing + trigger pattern alone places most patients into one of these four boxes — the single highest-yield step in the entire consultation.

> □ **Key Point:**
> Timing + triggers alone puts most dizzy patients into one of four diagnostic boxes. Everything else in the consultation refines the diagnosis within that category.

IV. Timing — The First Question

Timing has two components that must be established separately: (1) how long each discrete episode lasts, and (2) when it started and its overall time course.

The clinical signature of most vestibular diseases is defined by episode duration. Memorising the ranges below is worth more than any single investigation:

Table 2 — Episode Duration and Diagnostic Differential

Duration of each episode	Think of
Seconds (<1 minute)	BPPV, superior canal dehiscence, vestibular paroxysmia
Minutes (5–60 minutes)	Vestibular migraine, TIA
Hours (20 min to several hours)	Ménière's disease, vestibular migraine
Days (continuous >24 h)	Vestibular neuritis, labyrinthitis, posterior circulation stroke
Continuous for weeks to months	PPPD, bilateral vestibular loss, cerebellar disease

Episode duration is the single most diagnostically discriminating component of the history.

> **□ Clinical Pearl:**
> Ask "how long does each separate attack last, from the moment it starts until you feel completely back to normal?" Patients often confuse this with how long they have felt unwell overall. Clarify per-episode duration specifically.

Pitfalls in Asking About Timing

Patients with BPPV frequently report that dizziness "lasts all day" because every time they turn their head the symptom re-triggers. What they actually experience is many short attacks of seconds, interspersed with normal periods. Asking "between attacks, do you feel completely normal, or is there a lingering dizziness?" distinguishes BPPV from a continuous vestibular syndrome.

Patients with PPPD often describe their dizziness as "constant" but will describe clear exacerbations with movement and visual environments. Asking "is it worse with certain activities, or is it identical throughout the day?" teases this out.

V. Triggers — The Second Question

Triggers are any factor that reliably precipitates or worsens an episode. The presence, absence, or type of trigger is one of the most diagnostic pieces of information you can obtain.

Positional Triggers

The most important trigger to ask about is positional change. Ask specifically about rolling over in bed (particularly to one side), lying flat or getting up from lying, looking up (the "top-shelf" manoeuvre), and bending forward. Dizziness triggered by these actions and lasting seconds is BPPV until proven otherwise. A positive answer should prompt a Dix-Hallpike manoeuvre at the same consultation.

> **□ Clinical Pearl:**
> Distinguish "dizzy when I stand up" (orthostatic — pre-syncope, autonomic) from "dizzy when I lie down or roll over" (positional — BPPV). Patients and clinicians often lump these together. They are completely different diagnoses.

Visual Triggers

Ask about environments with complex or moving visual input: supermarket aisles, scrolling on a phone or computer screen, highway driving or being a passenger in a car, patterned floors, crowds, escalators. Visual triggers are characteristic of visually-induced dizziness, a defining feature of PPPD and vestibular migraine. Their presence has high specificity for these two conditions.

Other Triggers

- **Loud sounds or Valsalva:** superior canal dehiscence, perilymph fistula.
- **Exertion or head movement:** bilateral vestibular loss, rarely exercise-induced vertigo.
- **Menstrual cycle, sleep deprivation, stress, specific foods:** vestibular migraine.
- **Standing from lying or sitting:** orthostatic hypotension, autonomic failure, POTS.

> □ **Key Point:**
> No trigger = spontaneous episodic vertigo. Main differentials: vestibular migraine, Ménière's, TIA.
> Clear trigger = triggered episodic vertigo, of which BPPV is by far the most common cause.

VI. Associated Symptoms

Associated symptoms discriminate between peripheral and central vestibular disease, and between specific peripheral disorders.

Audiological Symptoms

- Hearing loss and tinnitus accompanying vertigo are highly suggestive of an inner ear cause.
- Fluctuating low-frequency hearing loss with aural fullness is the audiometric signature of Ménière's disease.
- Sudden sensorineural hearing loss with vertigo is an otological emergency — see the separate review on this topic.
- Hearing loss in one ear with progressive imbalance raises the possibility of vestibular schwannoma.

Neurological Symptoms

Any neurological symptom accompanying vertigo must be treated as a red flag for central causation until excluded. Ask specifically about diplopia, blurred vision not corrected by blinking, dysarthria, dysphagia, facial or limb weakness or numbness, incoordination disproportionate to the vertigo, and new or severe headache (particularly occipital).

Migraine Features

In vestibular migraine, headache may be absent during vertigo episodes. Ask instead about personal or family history of migraine, photophobia, phonophobia or osmophobia during episodes, visual aura preceding or during episodes, and nausea disproportionate to the vertigo.

Autonomic Symptoms

Lightheadedness with pallor, diaphoresis, palpitations, or the sensation of impending faint suggests pre-syncope — consider orthostatic hypotension, vasovagal, cardiac, or autonomic causes.

> □ **Clinical Insight:**
> Associated symptoms rarely change the diagnosis in isolation — they refine it. The TiTrATE pattern sets the category; associated symptoms pick the specific diagnosis within that category.

VII. Red Flags — When History Alone Mandates Referral or Imaging

Certain history features should prompt urgent specialist or emergency evaluation regardless of examination findings:

- Sudden onset severe vertigo in a patient with vascular risk factors, especially over age 50.
- Vertigo with any new neurological symptom (diplopia, dysarthria, weakness, numbness, ataxia).

- New occipital or severe headache with vertigo.
- Vertigo with sudden hearing loss — ENT emergency, window for steroid treatment <72 hours.
- Progressive imbalance with unilateral hearing loss — vestibular schwannoma until proven otherwise.
- Vertigo after head or neck trauma — consider vertebral artery dissection, labyrinthine concussion.
- Gait ataxia disproportionate to vertigo — central cause.
- Vertigo that wakes the patient from sleep (other than rolling over in bed) — uncommon for benign peripheral causes.

> □ **Important:**
> The commonest missed diagnoses in primary care are vestibular migraine (mistaken for anxiety), PPPD (mistaken for "functional dizziness"), and posterior circulation stroke (mistaken for vestibular neuritis). A red flag in the history is sufficient to over-ride an otherwise reassuring examination.

VIII. Patient Language and Common Pitfalls

Patients commonly use imprecise or metaphorical language that can mislead the clinician. A systematic approach:

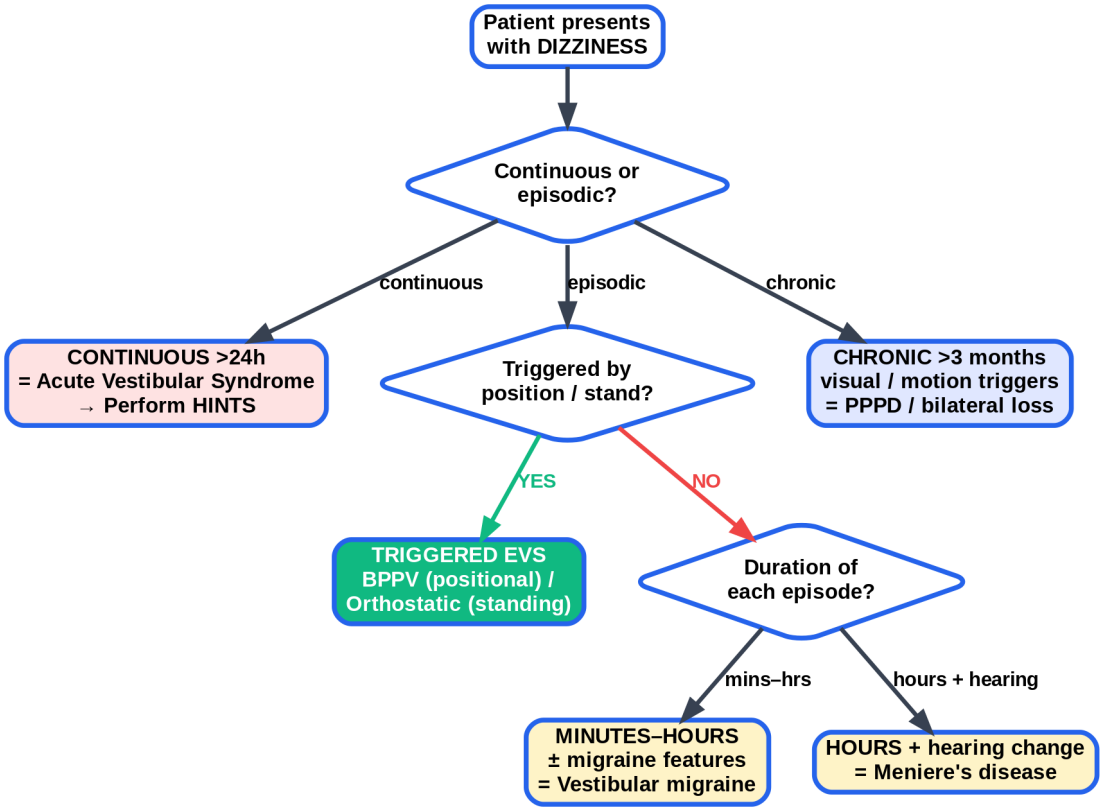
- **"Dizzy".** Re-ask: "Describe the feeling without using the word dizzy. What does it feel like inside your head?"
- **"Off-balance".** Ask if this is when walking (disequilibrium), in specific environments (PPPD, visual vertigo), or all the time (bilateral vestibular loss, cerebellar).
- **"Lightheaded".** Ask about orthostatic triggers, palpitations, near-faint.
- **"Spinning".** Confirms vertigo, but does not further localise.
- **"Rocking" or "swaying".** Common in PPPD and Mal de Débarquement syndrome.

> □ **Clinical Pearl:**
> If a patient says "dizzy", ask them to describe the sensation without using the word "dizzy". This single re-framing uncovers the true symptom in most cases and often reveals a diagnosis the patient has been carrying unrecognised for years.

IX. The 90-Second Dizziness History — A Clinical Algorithm

For the time-pressured clinician, a minimum history can be taken in under two minutes. The algorithm below is the distilled history engine behind every other section of this review.

Figure 1 — 90-Second Dizziness History Algorithm



Six questions, used consistently, will place almost every dizzy patient into the correct diagnostic category.

X. Documentation and Next Steps

A structured note protects the patient, guides the next clinician, and underpins medico-legal defensibility. Minimum documentation for a dizzy patient:

- Episode duration (seconds / minutes / hours / days / continuous).
- Time course (acute / subacute / chronic / fluctuating).
- Trigger pattern (none / positional / orthostatic / visual / auditory / specific).
- Associated symptoms (hearing, neurological, migrainous, autonomic).
- Red flags assessed and documented present/absent.
- Provisional diagnostic category (AVS / s-EVS / t-EVS / Chronic).
- Next step (bedside examination, referral, investigation, review).

> **□ Clinical Insight:**
> The transition from history to examination should be driven by the diagnostic category. AVS → HINTS. Triggered episodic → Dix-Hallpike. Spontaneous episodic → associated-symptom profiling. Chronic → full neuro-otological assessment. Don't do the whole examination on every patient; do the examination the history has told you to do.

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