

DIZZINESS, LIGHT HEADED
(example – vertigo)

Subjective Data:

Allergies: _____

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)

BP (sitting) _____ (lying) _____ (standing) _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____

Skin Color	Skin	Turgor	Neurological		Ears	Pulse
<input type="checkbox"/> Pink	<input type="checkbox"/> Warm	<input type="checkbox"/> Normal	<input type="checkbox"/> Awake	<input type="checkbox"/> Pupils equal	<input type="checkbox"/> No abnormalities noted	<input type="checkbox"/> Strong
<input type="checkbox"/> Pale	<input type="checkbox"/> Cool	<input type="checkbox"/> Pale	<input type="checkbox"/> Alert	<input type="checkbox"/> Pupils unequal	<input type="checkbox"/> Drainage	<input type="checkbox"/> Regular
<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Dry	<input type="checkbox"/> Decreased	<input type="checkbox"/> Oriented X_____	<input type="checkbox"/> Pupils constricted	<input type="checkbox"/> Trauma	<input type="checkbox"/> Weak
<input type="checkbox"/> Mottled	<input type="checkbox"/> Clammy		<input type="checkbox"/> Confused	<input type="checkbox"/> PERRLA	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Thready
<input type="checkbox"/> Jaundiced			<input type="checkbox"/> Lethargic	<input type="checkbox"/> Follows commands	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Irregular
			<input type="checkbox"/> Comatose	<input type="checkbox"/> Unable to follow commands		
			<input type="checkbox"/> Normal gait			
			<input type="checkbox"/> Abnormal gait			

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:

- 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

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

Alteration in mobility / sensation related to gait disturbances / vertigo

Plan:

Nursing Intervention Routine: Include First Aid

- Place in supine position with eyes open have offender stare straight ahead and place pillow on each side of head
- Antihistamine "Meclizine, (Antivert)" 1 p.o. 3 times day pending medical provider assessment (**This will require an order from the medical provider**)

Progress Note: _____

Offender Education:

- Instructed to sit when feeling dizzy to avoid injury, methods to decrease sensation of vertigo, medication use, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

RN/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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