

Center for Hypotension
Autonomic Questionnaire

Revised 11/29/06

Name: _____

Birth Date: _____

Age: _____

Gender: M F

Height: _____

Weight: _____

Address: _____

City/State/Zip Code: _____

Social Security Number _____

Telephone: (H) _____ (W) _____

(Cell) _____

Email Address: _____ Webpage: _____

Ethnic group:

- a. Caucasian (Non-Hispanic)
- b. African-American/Black (Non-Hispanic)
- c. Hispanic/White
- d. Hispanic/Black
- e. Asian
- f. Other (please specify) _____

Are you currently **working or going to school**? Yes _____ No _____

If you work, what is your current
occupation? _____

How many days of work or school have you missed in the last month because of
illness? _____

If no, when did you last work/school? _____ Doing what? _____

Allergies

To medication? _____

To food? _____

Other? _____

Have you been told that you have a disorder of the autonomic nervous system?

Yes _____ No _____

If so, by whom? _____

What did they call this disorder? _____

List your medical problems (e.g., diabetes, high blood pressure, asthma, kidney disease,
stroke, cancer, heart disease, etc.)

Primary Physician's Name: _____

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Primary Physician's Address and phone number: _____

Do you believe you have or have you been told that you have one of the following conditions?
(circle all that apply)

- | | |
|----------------------------------|-----------------------------|
| 1. mitral valve prolapse | 2. chronic fatigue syndrome |
| 3. fibromyalgia | 4. irritable bowel syndrome |
| 5. sick building syndrome | 6. hypoglycemia |
| 7. multiple chemical sensitivity | 8. dysautonomia |

Please list any diseases that you have been diagnosed with and dates:

Which of your problems is most troubling to you?

What do you hope to get from your visit?

When and how did your current symptoms begin?

Please list any medications that you are taking:

Name	Dose (mg)	Times per day
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Use the scale below to complete the list regarding your **symptoms and their frequency/month**:

1:Never 2:< 1 time 3:2-4 times 4:5-7 times 5:daily

1	2	3	4	5	
1	2	3	4	5	urinary incontinence or leaking
1	2	3	4	5	constipation
1	2	3	4	5	fatigue
1	2	3	4	5	nausea
1	2	3	4	5	headache
1	2	3	4	5	heartburn
1	2	3	4	5	clamminess of skin
1	2	3	4	5	tremulousness
1	2	3	4	5	impotence (for males)
1	2	3	4	5	sensation of rapid heartbeat
1	2	3	4	5	impaired memory
1	2	3	4	5	fainting
1	2	3	4	5	itching of the feet
1	2	3	4	5	chest discomfort

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1	2	3	4	5	sensation of forceful, slow heartbeat
1	2	3	4	5	dizziness
1	2	3	4	5	feeling of weakness
1	2	3	4	5	frequent waking during the night
1	2	3	4	5	shortness of breath
1	2	3	4	5	blurring or dimming of vision
1	2	3	4	5	difficulty emptying the bladder
1	2	3	4	5	excessive daytime sleepiness
1	2	3	4	5	loose, watery stools
1	2	3	4	5	anxiety
1	2	3	4	5	muscle aches
1	2	3	4	5	bloating after meals
1	2	3	4	5	itching of the hands
1	2	3	4	5	lightheadedness (faintness)
1	2	3	4	5	difficulty falling to sleep
1	2	3	4	5	difficulty with starting to urinate
1	2	3	4	5	sensation of head or room spinning
1	2	3	4	5	excessive sweating
1	2	3	4	5	confusion
1	2	3	4	5	neck or shoulder aching
1	2	3	4	5	joint aches
1	2	3	4	5	difficulty staying asleep

Please list your 3 main symptoms:

1) _____

2) _____

3) _____

How frequent are these symptoms?

- Never or almost never
- Several times a month
- Several times a week
- Daily

How severe are these symptoms?

- Mild
- Moderate
- Severe

How long have you had symptoms?

- Less than 1 month
- 1-3 months
- 6-12 months
- More than 1 year

Are they improving?

- Yes
- No
- No change

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Does anyone else in the family have these symptoms? Who? _

Which of your mother/father/sister/brother have had:

Diabetes _____
High blood pressure _____
Asthma _____
Heart disease _____
Kidney disease _____
Stroke _____
Cancer _____
Other disease _____

1. On average, how frequently do you feel dizzy or lightheaded?
 Almost all day long
 Several times a day
 Once or twice a day
 Several times a week
 Once or twice a week
 Once or twice a month
 Less than once a month
2. If you were frequently dizzy, did this begin before the illness? Yes No
3. Have you ever fainted (unconscious)? Yes No
4. Have you ever nearly fainted (not unconscious but blackout, or fell down from dizziness)? Yes No
5. If you fainted or nearly fainted, did this begin before the illness? Yes No
6. If you have fainted, nearly fainted, or been frequently (daily) dizzy is this related to exercise?
 Mostly or always occurs with exercise but not at rest
 Can occur without exercise but exercise makes it worse
 Not related to exercise
7. Does fainting or dizziness occur when you are standing or sitting?
 Always
 Almost always
 Never
 Not related to posture
8. Does fainting or dizziness get better when you lie down? Yes No
9. Does fainting or dizziness worsen with emotion or fear? Yes No
10. Are you Bedridden? Yes No
If yes for how long and explain _____

11. Which statement below best describes your usual desire for salt (check only one answer)
 I have no special craving for salt
 I occasionally have a craving for salt and salty foods

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I often crave salt and salty foods

12. Which statement below best describes your usual degree of thirst and fluid consumption

- I am thirsty all the time and drink frequently
- I am thirsty all the time but drink a normal amount
- I am normally thirsty and drink frequently
- I am normally thirsty and drink a normal amount
- I am rarely thirsty and drink frequently
- I am rarely thirsty and drink a normal amount
- I am rarely thirsty and drink infrequently

13. How long have you had symptoms?

- Less than 1 month
- 1-3 months
- 6-12 months
- More than 1 year

How often do you get the following symptoms:

a) Heartburn

- Never or almost never
- Several times a month
- Several times a week
- Daily

b) Feeling full after eating just a small amount of food

- Never or almost never
- Several times a month
- Several times a week
- Daily

c) Vomiting or a sensation that food is coming back up from your stomach

- Never or almost never
- Several times a month
- Several times a week
- Daily

d) Nausea

- Never or almost never
- Several times a month
- Several times a week
- Daily

e) Pain in the upper abdomen

- Never or almost never
- Several times a month
- Several times a week
- Daily

f) Constipation or diarrhea

- Constipation
- Diarrhea
- Normal

g) Trouble with urination

- No
- Yes

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h) Incontinence (wetting) or urinary retention

- No
- Incontinence
- Retention

i) Impotence

- No
- Yes

j) Vertigo (room spinning)

- Never or almost never
- Several times a month
- Several times a week
- Daily

k) Fast heart beat

- Never or almost never
- Several times a month
- Several times a week
- Daily

l) Have you or others observed a Pale or Gray color to your face?

- Never or almost never
- Several times a month
- Several times a week
- Daily

m) Discolored hands or feet

- Never or almost never
- Several times a month
- Several times a week
- Daily

n) Cold hands or feet

- Never or almost never
- Several times a month
- Several times a week
- Daily

o) Do you have pain in your hands or feet?

- Never or almost never
- Several times a month
- Several times a week
- Daily

p) Do you have pain in your legs?

- Never or almost never
- Several times a month
- Several times a week
- Daily

q) Hot and sweaty for no reason

- Never or almost never
- Several times a month
- Several times a week
- Daily

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r) Facial Flushing

- Never or almost never
- Several times a month
- Several times a week
- Daily

s) Are your other symptoms worsened by environmental heat?

- Never or almost never
- Several times a month
- Several times a week
- Daily

t) Do you have any breathing difficulty or feel that you do not get enough air?

- Never or almost never
- Several times a month
- Several times a week
- Daily

u) Headache or migraine

- Never or almost never
- Several times a month
- Several times a week
- Daily

v) Leg weakness

- Never or almost never
- Several times a month
- Several times a week
- Daily
- Daily but only standing up

w) Do you have mitral valve prolapse? Yes No

Do your symptoms occur when you are standing or sitting?

- Always
- Almost always
- Never
- Not related to posture

Do your symptoms get better when you lie down? Yes No

Do your symptoms get worse with exercise ? Yes No

Do your symptoms get worse with alcohol ? Yes No

Do your symptoms change during the menstrual cycle? Yes No

Are these symptoms related to dizziness or fainting? Yes No

Are these symptoms related to any specific medication that you take? Yes No

Please explain any abnormal findings

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Heart Rate and Blood Pressure Recordings

Please record your blood pressure and heart rate under the following conditions on three separate occasions. Lie quietly for 10 minutes and then take blood pressure and heart rate. Then stand in one place. At the end of 3 minutes and then again at 10 minutes, take blood pressure and heart rate. Record the results below. **This is VERY IMPORTANT. These records cannot be properly evaluated without this information.**

		blood pressure	heart rate
date_____ time_____	lying	_____	_____
	standing 3 min	_____	_____
	standing 10 min	_____	_____
date_____ time_____	lying	_____	_____
	standing 3 min	_____	_____
	standing 10 min	_____	_____
date_____ time_____	lying	_____	_____
	standing 3 min	_____	_____
	standing 10 min	_____	_____

How were these reading
taken?

- a. Who measured your blood pressure and heart rate? _____
- b. Does the cuff automatically make the measurements? _____
- c. Did you use an arm cuff or finger cuff. _____

Please return this form to:

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