Patient Label

DYSAUTONOMIA CENTER of EXCELLENCE at UT HEALTH and MEMORIAL HERMANN HOSPITAL

CLINICAL QUESTIONNAIRE

Patient name _____

Date _____

Age _____

Initial symptom _____ Age at _____

Specialist at time of presentation _____

SYMPTOMS (circle one)

HEADACHES Yes No

(0 = not severe; 10 = severe)

0 1 2 3 4 5 6 7 8 9 10

Duration: 0-6 hours 6-12 hours 12-24 hours +24 hours

Frequency: Infrequent Occasional Frequent Constant

Five - Point Scale

0 - *Never* or *almost never* have the symptom

1 - *Occasionally* have it, effect is *not severe*

2 - *Occasionally* have it, effect is *severe*

3 - *Frequently* have it, effect is *not severe*

4 - *Frequently* have it, effect is *severe*

N/A – Not applicable

NEUROLOGIC

Syncope (passing out)	0	1	2	3	4	N/A
Dizziness (light-headedness)	0	1	2	3	4	N/A
Vision changes	0	1	2	3	4	N/A
Aura (tunnel/blurred vision, etc.)	0	1	2	3	4	N/A
Vertigo (room moving)	0	1	2	3	4	N/A
Paresthesias (numbness or tingling)	0	1	2	3	4	N/A
Poor memory	0	1	2	3	4	N/A
Brain fog	0	1	2	3	4	N/A
Confusion, poor concentration	0	1	2	3	4	N/A
Poor physical coordination	0	1	2	3	4	N/A
Slurred speech	0	1	2	3	4	N/A
Learning disabilities	0	1	2	3	4	N/A

CARDIAC

Fast heartbeat	0	1	2	3	4	N/A
Slow heartbeat	0	1	2	3	4	N/A
High blood pressure	0	1	2	3	4	N/A
Low blood pressure	0	1	2	3	4	N/A
Skipped heartbeat	0	1	2	3	4	N/A
Pounding heartbeat	0	1	2	3	4	N/A
Chest pain/tightness	0	1	2	3	4	N/A

GENITOURINARY

Frequent urination	0	1	2	3	4	N/A
Urgent urination	0	1	2	3	4	N/A
Hesitancy	0	1	2	3	4	N/A
Urinary retention	0	1	2	3	4	N/A
Urinary incontinence	0	1	2	3	4	N/A

METABOLIC/IMMUNOLOGIC

Mitochondrial disorder	0	1	2	3	4	N/A
Diabetes	0	1	2	3	4	N/A
Thyroid disorder	0	1	2	3	4	N/A
Autoimmune condition	0	1	2	3	4	N/A

GASTROINTESTINAL

Nausea	0	1	2	3	4	N/A
Vomiting	0	1	2	3	4	N/A
Intestinal/stomach pain	0	1	2	3	4	N/A
Irritable bowel	0	1	2	3	4	N/A
Constipation	0	1	2	3	4	N/A
Diarrhea	0	1	2	3	4	N/A
Post-meal symptoms	0	1	2	3	4	N/A
Heartburn	0	1	2	3	4	N/A
Bloating	0	1	2	3	4	N/A

SKIN

Flushing, hot flashes	0	1	2	3	4	N/A
Paleness of face	0	1	2	3	4	N/A
Cyanosis (blue extremities)	0	1	2	3	4	N/A
Pale extremities	0	1	2	3	4	N/A
Cold extremities	0	1	2	3	4	N/A
Swelling of extremities	0	1	2	3	4	N/A
Excessive sweating (clammy)	0	1	2	3	4	N/A
Heat intolerance	0	1	2	3	4	N/A
Cold intolerance	0	1	2	3	4	N/A

JOINTS/MUSCLES

Pain or aches in joints	0	1	2	3	4	N/A
Pain or aches in muscles	0	1	2	3	4	N/A
Feeling of weakness	0	1	2	3	4	N/A
Painful trigger points	0	1	2	3	4	N/A

ENERGY/ACTIVITY

Fatigue, sluggishness	0	1	2	3	4	N/A
Apathy, lethargy	0	1	2	3	4	N/A
Hyperactivity	0	1	2	3	4	N/A
Sleep disturbance	0	1	2	3	4	N/A
Exercise intolerance (sports, activities)	0	1	2	3	4	N/A

SUPPLEMENTAL

AGGRAVATING FACTORS

/ / /

MEDICATIONS (Indicate previous or current)

Fludrocortisone (Florinef) _____

Salt _____

Beta-blocker _____

Midodrine _____

Amitriptyline (Elavil) _____

Triptan _____

SSRI _____

SNRI _____

Water _____

Sports drink _____

Other _____

PHYSICAL FINDINGS (Any previous diagnoses? Please explain)

Chiari malformation _____

Pseudotumor cerebri _____

Abnormal brain MRI _____

Abnormal EEG _____

Cardiac abnormality _____

Psychiatric illness (ie: anxiety, depression, etc.) _____

Learning disability _____

Dental abnormality _____

FAMILY HISTORY (Any of the above symptoms/conditions)

Mother _____

Father _____

Siblings _____

Extended _____