Vanderbilt Autonomic Dysfunction Center
Medical Questionnaire

Date _______________

1. Contact Information

Name: ____

Age: __________ Date of birth: ____________________ Sex: __ female__ male

Home Address: ____

City: ___________________________ State _______________________ Zip ________________

Home phone: _____________________________ Cell phone: ___________________________

Email address: ____

Person to contact case of emergency (include name, home address and phone numbers):

____

____

____

2. Your Blood Pressure and Heart Rate:

Please have your physician take your **blood pressure AND heart rate** while lying down and standing on three separate dates, preferably early in the morning at least 2 hours after a meal (or you can have a caregiver help you do this if you have a home blood pressure machine). **This is a very important part of our evaluation. Without this information we may not be able to schedule a correct appointment.**

		Blood Pressure	Heart Rate
1st Measurement	Lying down	_____________	___________
	Standing up for one minute	_____________	___________
	Standing up for three minutes	_____________	___________
2nd Measurement	Lying down	_____________	___________
	Standing up for one minute	_____________	___________
	Standing up for three minutes	_____________	___________
3rd Measurement	Lying down	_____________	___________
	Standing up for one minute	_____________	___________
	Standing up for three minutes	_____________	___________

Please have your physician send **relevant** medical records to one of these addresses as directed

Autonomic Clinic
Vanderbilt Heart Institute
1215 21st Avenue South
Nashville, TN 37232
FAX: 615-936-8208
Phone: 615-322-2318

Research Office
AA3228 MCN, Vanderbilt University
1161 21st Ave South
Nashville, TN 37232-2195
FAX: 615-343-8649

3. Prior Diagnosis: Has a physician ever told you that you had (check all that apply):

- ☐ Postural Tachycardia syndrome (POTS) or orthostatic intolerance or inappropriate tachycardia (rapid heart-beat) on standing?
- ☐ Orthostatic Hypotension (drop in blood pressure on standing)?
- ☐ Pure Autonomic Failure (PAF)?☐
- ☐ Multiple System Atrophy (MSA) or Shy-Drager Syndrome (SDS)?
- ☐ Parkinson's disease with orthostatic hypotension or autonomic dysfunction?
- ☐ Diabetes Mellitus (high blood sugar) with autonomic dysfunction?
- ☐ Syncope/fainting?
- ☐ Other (please describe):

☐☐ ____

4. Current Medications

Medication	Dose	How often do you take it?
____________________________	______	______________________
____________________________	______	______________________
____________________________	______	______________________
____________________________	______	______________________
____________________________	______	______________________
____________________________	______	______________________

5. Medications you have tried for your autonomic problem

Medications that have not been effective

____

____

____

Medications that you could not tolerate	and the reason why
____________________________	______________________
____________________________	______________________
____________________________	______________________

6. Present Illness

Explain in your own words the **MAIN** medical problem you have. (Please be concise and do not exceed the space provided; we need to have an idea of what the **main** problem is).

7. Past/Other Medical Problems & Prior Surgeries

1. ________________________ 5. ________________________
2. ________________________ 6. ________________________
3. ________________________ 7. ________________________
4. ________________________ 8. ________________________

8. List Any Major Physical or Psychological Traumatic Event you have had in your life

____
____
____
____

9. Review of Systems (mark all symptoms you have)

- ☐ Episodes of Fainting
- ☐ Symptoms on standing (e.g., lightheadedness), that are relieved by sitting down
- ☐ Vertigo (room spinning around you)

- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Chest pain
- ☐ Episodes of flushing (face or neck turning bright red)

- ☐ Profuse sweating
- ☐ Stop sweating
- ☐ Recent change in bowel movements with diarrhea
- ☐ Recent onset or worsening of constipation
- ☐ Loss of bowel control
- ☐ Vomiting
- ☐ Weight loss of over 10 pounds in the last year

- ☐ Frequent urinations
- ☐ Increased urinations in the night
- ☐ Difficulty holding urine
- ☐ Difficulty starting urination (urinary retention, prostate symptoms in men)
- ☐ Frequent urinary infections
- ☐ Numbness, burning or tingling in feet
- ☐ Decreased sense of smell
- ☐ Handwriting becoming shaky
- ☐ Handwriting becoming smaller in size
- ☐ Decreased facial expression
- ☐ Jerking of legs during sleep
- ☐ Acting up dreams, shouting/yelling or swearing during sleep, or having violent behaviours or hurt yourself or someone else while sleeping
- ☐ Hallucinations
- ☐ Memory problems
- ☐ Mental confusion

10. Expanded Past Medical History

1. Drug Allergies and Reaction?____
   ____
   ____
   ____
   ____

2. When was the last time you had immunizations (shots) for tetanus ________________________

   Flu _____________________ Pneumonia_________________________ HPV _____________

3. Do you follow a special diet? ______________ If yes, please explain. _____________________

   ____

4. Coffee: Number of cups per day _________

5. If still menstruating, date of last period

   ____

   Number of pregnancies ___________ Miscarriages ________ Stillbirths ________

   Induced abortions _________ Stillbirths _________

   Number of children born alive ___________

   Number of caesarean sections __________

   Complications of pregnancy (hemorrhage, toxemia) ___________________________________

11. Social History

Smoke?	Y	N	How much?_____________________________
Alcohol?	Y	N	How much?_____________________________
Recreational Drugs?	Y	N	Name of drug(s) and How much?

____

____

Occupation: ____

Did you have to stop work because of your symptoms? ____, if yes, when?__________________

Marital Status: ____________ # of Children? : ____________

12. Expanded Family History

Family History (if deceased, please note cause of death):

	Diseases	Deceased?		Cause of death
Father:	____	Y	N	________________________
Mother:	____	Y	N	________________________
Children:	______________________________________	Y	N	________________________
Other:	____	Y	N	________________________

Are there any diseases that "run in the family"?

Disease	Family member(s) affected
______________________________	____
______________________________	____
______________________________	____
______________________________	____