DYSAUTONOMIA **NEW PATIENT QUESTIONNAIRE** **DR. SCHOFIELD**

Date:_____

Patient Name:_____ **Date of Birth:**_____

University of Colorado Medical records **Yes** **or** **No** **IMMUNOe records** **Yes** **or** **No**

GENERAL

Who referred you for today's consultation?

What are your goals for today's consultation?

When/How did your illness/symptoms begin?

Did anything seem to trigger your illness (ex: surgery, vaccine, infection, other) ☐ No ☐ Yes If yes please explain:

What symptoms seem to bother you the most?

1)

2)

3)

4)

Has your illness affected your performance and/or ability to work or attend school? ☐ No ☐ Yes If yes please explain:

If your best level of functioning was 100%, what has been your average level of functioning over the last month? _____%

EXERCISE

Do you exercise on a regular basis? ☐ No ☐ Yes Hours/week:

Type:

Does exercise make your symptoms worse? ☐ No ☐ Yes

FLUIDS/SALT INTAKE

How much liquid do you drink on average a day? ____oz _____liters

Do you add extra salt to your food regularly? ☐ No ☐ Yes How much?

SPECIALIST

Have you seen a Cardiologist for this illness? ☐ No ☐ Yes Name:

Have you seen a Neurologist for this illness? ☐ No ☐ Yes Name:

Have you seen a Gastroenterologist for this illness? ☐ No ☐ Yes Name:

Have you seen a Rheumatologist for this illness? ☐ No ☐ Yes Name:

Have you seen any other specialist for this illness? ☐ No ☐ Yes Name:

MEDICATIONS TRIED

Have you been prescribed/tried any of the following:			If yes, did it help with your symptoms? Please describe response—good or bad.
Beta blockers (e.g. Propranolol, Metoprolol, Atenolol, Bystolic)	☐ No	☐ Yes	
Florinef (Fludrocortisone)	☐ No	☐ Yes	
Midodrine	☐ No	☐ Yes	
Mestinon	☐ No	☐ Yes	
Ivabradine (Corlanor)	☐ No	☐ Yes	
Stimulants (e.g. Adderall, Ritalin, Concerta, Vyvanse)	☐ No	☐ Yes	
SSRI (e.g. Celexa, Lexapro, Prozac, Paxil, Zoloft)	☐ No	☐ Yes	
SNRI (e.g. Effexor, Cymbalta, Pristiq, Savella)	☐ No	☐ Yes	
NDRI (Wellbutrin)	☐ No	☐ Yes	
TCA (ex: Elavil, Pamelor, Doxepin)	☐ No	☐ Yes	
Benzos (e.g. Ativan, Valium, Klonopin)	☐ No	☐ Yes	
Marijuana	☐ No	☐ Yes	
H1 blockers (e.g. Zyrtec, Xyzal, Claritin, Atarax, Benadryl, Allegra, Ketotifen)	☐ No	☐ Yes	
H2 blockers (e.g. Zantac, Pepcid)	☐ No	☐ Yes	
Cromolyn	☐ No	☐ Yes	
Xolair (Omalizumab)	☐ No	☐ Yes	
Imatinib (Gleevec)	☐ No	☐ Yes	
Quercetin	☐ No	☐ Yes	
Intravenous immunoglobulin (IVIG)	☐ No	☐ Yes	
Rituximab (Rituxan)	☐ No	☐ Yes	
Compression stockings and/or abdominal binder	☐ No	☐ Yes	
Other immune modulatory therapy	☐ No	☐ Yes	
Other (please list):			

CURRENT MEDICATIONS

Please complete the *current medication form*.

DIAGNOSTIC TESTING HISTORY

Have you had any of the following performed?

Tilt table test	☐ No	☐ Yes	Date:
In-office stand test	☐ No	☐ Yes	Date:
Autonomic reflex test	☐ No	☐ Yes	Date:
QSART test	☐ No	☐ Yes	Date:
Skin biopsy for small fiber neuropathy	☐ No	☐ Yes	Date:
Electromyography (EMG)/Nerve conduction velocity (NCV)	☐ No	☐ Yes	Date:
Echocardiogram	☐ No	☐ Yes	Date:
Heart monitoring	☐ No	☐ Yes	Date:

Cardiac stress test	☐ No	☐ Yes	Date:
Brain MRI	☐ No	☐ Yes	Date:
Spine MRI	☐ No	☐ Yes	Date:
Other tests	☐ No	☐ Yes	Date:

PERTINENT LABS

SOCIAL HISTORY

What city/state do you live in?			
What is your occupation?			
Marital Status	☐ S	☐ M	☐ D
Do you have children?	☐ No	☐ Yes	Age(s):
Do you smoke cigarettes?	☐ No	☐ Yes	
Do you consume alcohol?	☐ No	☐ Yes	Consumption: ☐ Social ☐ Daily ☐ Rarely
Do you use marijuana?	☐ No	☐ Yes	
Have you ever used any other drugs?	☐ No	☐ Yes	

PAST MEDICAL HISTORY

Please list any important medical problems *(current or past)*:

PAST SURGICAL HISTORY

Please list any important previous surgical history *(including approx. date)*:

FAMILY HISTORY

Does anyone in your family have a history of any of the following?			**Please provide any details.**
Autoimmune disease (e.g. lupus, multiple sclerosis, rheumatoid arthritis, Crohn's disease, celiac disease juvenile diabetes, etc)	☐ No	☐ Yes	
Dysautonomia	☐ No	☐ Yes	
Connective tissue disorder (ex: Marfan Syndrome, Ehlers-Danlos Syndrome)	☐ No	☐ Yes	
History of aortic aneurysm or sudden cardiac death at age <50 years	☐ No	☐ Yes	

Please note any other family history you feel may be important to your current issue or if your family history is unobtainable:

DYSAUTONOMIA	NEW PATIENT QUESTIONNAIRE		DR. SCHOFIELD
DYSAUTONOMIA SYMPTOMS			
Fatigue (mild, moderate or severe)?	☐ No	☐ Yes	
Exercise intolerance?	☐ No	☐ Yes	
Lightheadedness with standing?	☐ No	☐ Yes	
Syncope (passing out)?	☐ No	☐ Yes	
Palpitations and/or Tachycardia?	☐ No	☐ Yes	
Muscle twitches and/or cramps?	☐ No	☐ Yes	
Numbness and/or paresthesias?	☐ No	☐ Yes	
Temperature and/or sweating dysregulation?	☐ No	☐ Yes	
Bladder symptoms (do not count symptoms due to a documented urinary tract infection)?	☐ No	☐ Yes	
Headache?	☐ No	☐ Yes	How many days per month?
Brain fog and/or memory loss?	☐ No	☐ Yes	
GASTROINTESTINAL SYMPTOMS			
Nausea and/or vomiting?	☐ No	☐ Yes	
Feeling full quickly after eating?	☐ No	☐ Yes	
Diarrhea?	☐ No	☐ Yes	
Constipation?	☐ No	☐ Yes	
Abdomina pain?	☐ No	☐ Yes	
Weight loss?	☐ No	☐ Yes	Details:
DEPRESSION	☐ No	☐ Yes	
ANXIETY	☐ No	☐ Yes	
PAIN	☐ No	☐ Yes	Location: Severity: ☐ Mild ☐ Mod ☐ Severe
SLEEP DISTURBANCE			
Trouble falling asleep?	☐ No	☐ Yes	
Do you wake up in the middle of the night regularly?	☐ No	☐ Yes	If yes why?
Racing heart?	☐ No	☐ Yes	
Pain?	☐ No	☐ Yes	
Vivid dreams/nightmares?	☐ No	☐ Yes	
Snoring?	☐ No	☐ Yes	
About how many hours of “restful” sleep do you get each night? _____/hrs.			
AUTOIMMUNITY SYMPTOMS			
Do you experience any of the following symptoms on a more than occasional basis?			
Patches of hair loss?	☐ No	☐ Yes	
Dry eyes/dry mouth (not medication related)?	☐ No	☐ Yes	
Trouble wearing contacts?	☐ No	☐ Yes	
Raynaud’s phenomenon (fingers/toes turn white/blue in cold)?	☐ No	☐ Yes	

Rash on your cheeks that lasts for a few days at a time?	☐ No	☐ Yes	
Recurrent joint pain?	☐ No	☐ Yes	
Recurrent joint swelling?	☐ No	☐ Yes	Details:
Have you ever been pregnant?	☐ No	☐ Yes	Details:
Have you ever had a miscarriage, pre-eclampsia or HELLP syndrome?	☐ No	☐ Yes	Details:
Have you ever had a blood clot, heart attack or stroke?	☐ No	☐ Yes	Location/Date:
Migraine with aura (vision change, numbness or weakness before the headache onset)?	☐ No	☐ Yes	

MAST CELL ACTIVATION SYNDROME SYMPTOMS

Do you experience any of the following symptoms on a more than occasional basis?			
Flushing (face/neck turns red and/or warm spontaneously)?	☐ No	☐ Yes	How often?
Do other symptoms occur w/ flushing?	☐ No	☐ Yes	If yes please explain:
Episodes of intense pruritus?	☐ No	☐ Yes	How often?
Recurrent hives?	☐ No	☐ Yes	How often?
Unexplained rashes that come and go?	☐ No	☐ Yes	How often?
Anaphylaxis or a severe allergic reaction?	☐ No	☐ Yes	
Unexplained episodes of swelling in your arms or legs?	☐ No	☐ Yes	
Nasal/sinus congestion without upper respiratory infection?	☐ No	☐ Yes	
Hoarseness?	☐ No	☐ Yes	
Episodes of wheezing without at known history of asthma?	☐ No	☐ Yes	
Gastritis/ulcers/heartburn?	☐ No	☐ Yes	
Recurrent drenching night sweats?	☐ No	☐ Yes	

JHS (EHLERS-DANLOS SYNDROME / HYPERMOBILITY) SYMPTOMS

Criteria 1

Can you now, or could you ever, touch your hands flat on the floor without bending your knees?	☐ No	☐ Yes	
Can you now, or could you ever, bend your thumb to touch your forearm?	☐ No	☐ Yes	
As a child, did you amuse your friends by contorting your body into shapes or could you do the splits?	☐ No	☐ Yes	
As a child or teenager, did your shoulder or kneecap dislocate on more than one occasion?	☐ No	☐ Yes	
Do you consider yourself to be “double-jointed”?	☐ No	☐ Yes	

Criteria 2

Feature A			
Is your skin unusually soft or velvety?	☐ No	☐ Yes	
Is your skin unusually stretchy?	☐ No	☐ Yes	
Do you have stretch marks?	☐ No	☐ Yes	
Have your ever had a hernia?	☐ No	☐ Yes	
Do you form thin “cigarette paper” scars?	☐ No	☐ Yes	
Have you ever had pelvic floor, rectal and/or uterine prolapse?	☐ No	☐ Yes	

Do you or did you have dental crowding before braces?	☐ No	☐ Yes	
Do you have a high arched or narrow palate?	☐ No	☐ Yes	
Feature C	☐ No	☐ Yes	
Do you have daily joint pain in two or more limbs for longer than three months?	☐ No	☐ Yes	
Do you have daily wide spread pain for longer than three months?	☐ No	☐ Yes	
Do your joints ever spontaneously pop out of place?	☐ No	☐ Yes	

CCI (CHIARI/CRANIO-CERVICAL INSTABILITY) SYMPTOMS

Do you experience any of the following symptoms on a more than occasional basis?

Pain in your neck and/or back of your head?	☐ No	☐ Yes	How often?
Pain behind your eyes?	☐ No	☐ Yes	How often?
Headache that worsens with exercise, coughing, sneezing, bearing down and/or looking up?	☐ No	☐ Yes	How often?
Double vision?	☐ No	☐ Yes	How often?
Trouble swallowing?	☐ No	☐ Yes	How often?
Trouble with balance?	☐ No	☐ Yes	How often?
Numbness in your fingers or toes?	☐ No	☐ Yes	How often?
If you touch your chin to your chest, do you experience any symptoms?	☐ No	☐ Yes	If yes please explain:

CSF LEAK SYMPTOMS

Have you ever had a spinal tap or epidural?	☐ No	☐ Yes	Date(s):
Have you ever had surgery on your spine?	☐ No	☐ Yes	Date(s):
Have you been diagnosed with arthritis in multiple levels of your spine?	☐ No	☐ Yes	
Do you have ringing in your ears or change in your hearing?	☐ No	☐ Yes	
Do you have daily headaches?	☐ No	☐ Yes	Onset date:
Gone or better in AM?	☐ No	☐ Yes	
Worse in PM?	☐ No	☐ Yes	
Worse with cough, sneezing, laughing and/or exertion?	☐ No	☐ Yes	

OTHER SYMPTOMS

Please list any other symptoms which you are concerned about: