Barrow Autonomic Clinic Consultation

Dr Ram Narayan and Dr Jennifer Robblee

1. When did you last felt 100% normal:_____

2. When you first got sick, what were your first symptom(s):
   _____
   _____
   _____

3. Name your top three most disabling symptoms now:
   A._____
   B._____
   C._____

4. What makes you worse:_____

5. What makes you better:_____

6. Do you have Dizziness/Lightheaded: YES☐ NO☐
   IF YES:
   a. When did it start:_____
   b. Describe the sensation of it:_____
   c. How often do you feel dizzy?_____
   d. Is the dizziness mainly with standing? YES☐ NO☐ Sometimes☐
   e. Do you get Racing heart and/or Palpitations: YES☐ NO☐
   f. Do you faint (ie pass out unconscious): YES☐ NO☐ Near faint only☐

7. Are you constantly more tired than everyone else: YES☐ NO☐

8. How many minutes / hours can you stand: _____

9. How many minutes / hours can you sit: _____

10. Are you able to exercise? YES☐ NO☐
If yes -> What exercise & how often:_____

11. After low level activity (physical or mental) do you become exhausted within 24h:
YES☐ NO☐

12. Sleep:
a. Is your sleep refreshing: YES☐ NO☐
b. Do you snore: YES☐ NO☐
c. How many hours do you sleep at night: _____
d. How many hours do you sleep in the daytime:_____

13. Hydration status and salt intake:
a. What volume of water/liquid do you drink each day
b. What is your salt intake? LOW☐ NORMAL☐ HIGH☐
c.

14. How much caffeine do your drink? _____

15. Food
a. How many meals do you eat per day:_____
b. Any special diet:_____
c. Any weight changes: _____
d. Are you able to eat the same size meal as everyone else? YES☐ NO☐

16. Bowel function:
Do you have constipation: YES☐ NO☐
Do you have diarrhea: YES☐ NO☐
Do have stomach pain: YES☐ NO☐
Do you have nausea: YES☐ NO☐
Do you vomit often: YES☐ NO☐
Do you feel bloated: YES☐ NO☐

17. Any problems with peeing:_____

18. Any sexual dysfunction:_____

19. Do you have temperature intolerance?
Cold intolerance☐ Heat intolerance☐ Neither☐

20. Do you have abnormal sweating?
☐Yes, I have increased sweating -> Where?_____
☐Yes, I have decreased sweating -> Where?_____
☐No, I have normal sweating

21. Do you have dry eyes or excessive tearing of eye?
☐Yes, I have dry eyes -> Can you make tears? YES☐ NO☐
☐Yes, I have excessive tearing
☐No

22. Do you have any vision changes:_____
Are you sensitive to bright lights: YES☐ NO☐

23. Do you have any numbness (lack of sensation) or tingling (e.g. pins and needles)
☐Yes -> Where and how often:_____
☐No

24. Do you have any hearing changes?
I have reduced hearing: LEFT☐ RIGHT☐ NO☐
I have ringing in my ears: LEFT☐ RIGHT☐ NO☐
Are you sensitive to loud noise YES☐ NO☐

25. Do you have any memory changes:_____

26. Do you have skin changes like flushing:_____

27. Are you sensitive to strong smells: YES☐ NO☐

28. Do you have Headaches? YES☐ NO☐
    a. When did the headaches start?_____
    b. How many days per month are you 100% headache free:_____
    c. How often do you have a severe headache:_____
    d. How long does a severe headache last:_____
    e. Rate your headache severity out of 10:_____
    f. Does your headache go away when you lie flat: YES☐ NO☐

29. Please name where else you have pain:_____
_____
_____

30. Are you hypermobile (double-jointed): YES☐ NO☐

31. Have you ever had a head injury, concussion, or whiplash? If Yes, please describe:
_____
_____

32. Please list other symptoms that you are experiencing:
_____
_____

33. Please describe what daily activities like housework, school, work, child care, etc you are unable to do as a result of your symptoms:
_____

34. Are you on disability? YES☐ NO☐
If yes, what type of disability:_____
If yes, when did you go on disability:_____

35. Is anyone else treating you for these symptoms?
_____
_____

36. What treatments have been tried for your symptoms? Please note them below or bring records with what you have tried including dose and your response:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

37. What are you goals for this consultation?_____

38. Is there anything else you want to ensure we know?
_____
_____
_____
_____