

Name: _____ DODID: _____ Date: _____

Autonomic Dysfunction Worksheet

Review of Systems:

Gen: Exercise Intolerance, Fatigue, Cold or Heat Intolerance, Decreased or Increased Sweating

CV/Pulm: Lightheadedness, Dizziness, Chest Pain, Palpitations, Shortness of Breath

GI/GU: Constipation, Diarrhea, Nausea, Early Satiety, Urinary Urgency or Incontinence

Neuro: Headaches, Neckache (coat-hanger pain)

If POSITIVE for CV/Pulm, please complete orthostatic vital signs as below.

Orthostatic Vital Signs Procedure Sheet

Date: _____ Time: _____

1. Recumbent Data: Ideally, patient should lie recumbent for 20 minutes for baseline testing.

Duration recumbent prior to measures (10-20 minutes): _____

Blood Pressure: _____ Heart Rate: _____

2. Standing Data: Testing blood pressure and heart rate immediately upon standing and every minute for 10 minutes immediately after standing. Please record any symptoms or clinical signs in comment section.

Time	Blood Pressure	Heart Rate	Comments/Patient Sx
0 minutes			
1 minutes			
2 minutes			
3 minutes			
4 minutes			
5 minutes			
6 minutes			
7 minutes			
8 minutes			
9 minutes			
10 minutes			