Name_____

Postural Orthostatic Hypotension Syndrome (P.O.T.S.) Questionnaire:

1. Rate your level of fatigue on a scale of 1-10 (1= not very fatigued, 10= extremely fatigued). ___

2. If appropriate, to what degree do your abdominal symptoms (pain, constipation, diarrhea, etc.) affect your life? (1= not very much, 10= greatly). _____

3. How often have you felt faint upon standing or with prolonged standing in the past month? (1=not at all 2=occasionally 3=frequently 4=always) ___

4. If appropriate, to what degree does your anxiety and/or depression affect your life? (1= not very much, 10=greatly) ____

5. If appropriate, to what degree does your decreased concentration (brain fog) affect your life? (1= not very much, 10= greatly) ____

6. Please rate your current quality of life. (1= wonderful quality of life, 10= poor quality of life) ___

7. Please list the complaints which most greatly affect your life and/or cause you the greatest discomfort if not already discussed above, and assign each a number from 1-10 based on severity (1= not too bad, 10= very bad) Attach additional sheet if necessary

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