Patient Name: _____

Patient DOB: _____

Patient Phone: _____

Patient Email: _____

CENTER FOR COMPLEX NEUROLOGY
EDS & POTS

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I am pleased that you are seeking my help with your medical issues. In order to best help you, I ask that you please complete this form. I realize it is very lengthy, but getting this information prior to your appointment will save time and, therefore, give us more time during your appointment to discuss all the issues that are bothering you.

Prior to coming in for your appointment, we will need you to complete some forms so we can obtain medical records and ensure your visit goes smoothly. On the day of your appointment you might be seen first by a physician's assistant, but I will personally speak with you and examine you as well. I appreciate your working with me and my office to facilitate your evaluation at the Center for Complex Neurology, EDS & POTS. I look forward to seeing you.

David Saperstein, MD

Please answer the following questions as best as you can.

Check the box for any condition you have been diagnosed with.

- [ ] Ehlers-Danlos Syndrome (EDS)
- [ ] Joint hypermobility syndrome (JHS)
- [ ] Postural orthostatic tachycardia syndrome (POTS)
- [ ] Dysautonomia
- [ ] Syncope
- [ ] Mitral valve prolapse
- [ ] Gastroparesis
- [ ] Irritiable bowel syndrome (IBS)
- [ ] Celiac disease
- [ ] Gluten sensitivity
- [ ] Intersitital cystitis
- [ ] Migraines
- [ ] Chiari malformation
- [ ] Tempormandibular joint dysfunction (TMJ)
- [ ] Neuropathy
- [ ] Pinched nerve in neck
- [ ] Pinched nerve in back
- [ ] Mast cell activation syndrome (MCAS)
- [ ] Asthma
- [ ] Raynauds
- [ ] Depression
- [ ] Anxiety
- [ ] ADHD
- [ ] Bipolar
- [ ] PTSD
- [ ] Autoimmune disease
- [ ] Polycystic Ovary Syndrome

JOINTS

Please check the box if you have any of these symptoms

- [ ] Double jointed
- [ ] Pain in joints
- [ ] Joints slide in and out of place
- [ ] Dislocated joints (you have to do something to get the joint back into place)

Check which joints are involved

- [ ] Shoulders
- [ ] Elbows
- [ ] Wrists
- [ ] Fingers
- [ ] Ribs
- [ ] Hips
- [ ] Knees
- [ ] Ankles
- [ ] Toes

PAIN AND HEADACHES

- [ ] Neck pain
- [ ] Neck pain that shoots into arms or hands
- [ ] Back pain
- [ ] Back pain that shoots into hips or legs
- [ ] Numbness or tingling on a frequent basis

Check where numbness or tingling occurs

- [ ] Face
- [ ] Arms
- [ ] Hands
- [ ] Chest
- [ ] Stomach
- [ ] Legs
- [ ] Feet

Headaches

How often are the headaches?

- [ ] More than 3 times per week
- [ ] 1 to 2 per week
- [ ] 1 to 2 per month
- [ ] less than 1 per month

Where are the headaches?

- [ ] Back of head
- [ ] Front
- [ ] Temples
- [ ] Behind eyes
- [ ] All over

Do any of these occur with your headaches?

- [ ] Nausea
- [ ] Vomiting
- [ ] Light sensitivity
- [ ] Sound sensitivity
- [ ] Seeing flashing lights or zig-zagging lines

What to you do when you get a headache? _____

What medications have you tried in the past (to take during a headache or to prevent headaches)? _____

_____

Check if any of these apply to your jaw

- [ ] Pain
- [ ] Popping
- [ ] Clicking
- [ ] Difficulty chewing
- [ ] Jaw gets stuck or dislocates
- [ ] Treated for TMJ
- [ ] Currently using a mouth guard

LIGHTHEADEDNESS

Check if you get any of these symptoms

- ☐ Light headedness with standing
- ☐ Light headedness or dizziness while sitting or lying down
- ☐ Rapid heart beat
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Tunnel vision or vision going black or white
- ☐ Fainting
- ☐ Sweating too much
- ☐ Not sweating enough

Check if the above symptoms worsen after any of these activities

- ☐ Eating
- ☐ Showering
- ☐ Going outside in the heat

GASTROINTESTINAL

Check if you are bothered by any of these symptoms

- ☐ Stomach pain
- ☐ Stomach bloating or getting full easily
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Sensitivity to foods

Which foods? _____

GENITOURINARY

Check if you are bothered by any of these symptoms

- ☐ Dry mouth
- ☐ Dry eyes
- ☐ Urinating frequently
- ☐ Trouble urinating
- ☐ Urinary incontinence (loss of urine)

- [ ] Problems affecting sexual relations
- [ ] Decreased sex drive
- [ ] Pain with sex
- [ ] Trouble getting an erection
- [ ] Menopause
- [ ] Vaginal dryness

SLEEP AND ENERGY

Check if you have any of these problems

- [ ] Trouble falling asleep
- [ ] Trouble staying asleep
- [ ] Sleepiness during the day
- [ ] Trouble concentrating
- [ ] Trouble remembering things
- [ ] "Brain fog"

SKIN

Check if you are bothered by any of these issues

- [ ] Change in skin color in hands or feet
- [ ] Easy bruising
- [ ] Frequent rashes
- [ ] Hives
- [ ] Anaphylaxis
- [ ] Flushing or warm feeling in face or chest
- [ ] Trouble getting numb from local anesthetics
- [ ] Poor healing after surgery or injuries

PREGNANCY (FOR WOMEN)

How many time have you been pregnant? _____

How many children do you have? _____

Check if you had any of these pregnancy complications

- [ ] Preterm labor
- [ ] Premature rupture of membranes
- [ ] Uterine rupture
- [ ] Miscarriage

FAMILY HISTORY

List any relatives who have symptoms like yours _____

_____

_____

How many sisters do you have _____

How many brothers do you have _____

How many brothers or sisters does/did your mother have _____

How many brothers or sisters does/did your father have _____

Check if anyone in your family had any of these conditions

- ☐ Aneurysms
- ☐ Ruptured organs
- ☐ Migraines
- ☐ Seizures
- ☐ Mental retardation
- ☐ Hearing problems before age 40
- ☐ Vision problems before age 40

Have you ever had genetic testing? ☐ Yes ☐ No

Has anyone in your family had genetic testing? ☐ Yes ☐ No

SUMMARY

On a day to day basis, what 2 or 3 things bother you the most?

_____

_____

_____

On a scale of zero to ten rate how much you are bothered by:

_____ Joint problems

_____ Headaches

_____ Neck pain

_____ Back pain

_____ Other pain

_____ Lightheadedness

_____ Rapid heart beat

_____ Feeling anxious

_____ "Brain fog"

_____ Fatigue

_____ Trouble sleeping

_____ Digestive problems

_____ Allergic reactions

PRIOR EVALUATION AND TREATMENT

Check the box for any of the following specialists you have seen

- ☐ Allergist/Immunologist
- ☐ Cardiologist
- ☐ Endocrinologist
- ☐ Gastroenterologist
- ☐ Geneticist
- ☐ Neurologist
- ☐ Neurosurgeon
- ☐ Orthopedist
- ☐ Pain Specialist
- ☐ Psychiatrist
- ☐ Psychologist/Therapist
- ☐ Rheumatologist
- ☐ TMJ Specialist

Check the box of any of these tests you have had

- ☐ Echocardiogram
- ☐ Holter monitor
- ☐ Tilt table test
- ☐ Autonomic reflex test
- ☐ Nerve conduction studies (NCS)
- ☐ Electromyogram (EMG)
- ☐ Electroencephalogram (EEG)
- ☐ Gastric emptying study
- ☐ Colonoscopy/Endoscopy
- ☐ MRI brain
- ☐ MRI cervical spine
- ☐ MRI lumbar spine
- ☐ Allergy testing

Have you had P.T.? ☐ Yes ☐ No Are you currently in P.T.? ☐ Yes ☐ No

Have you had O.T.? ☐ Yes ☐ No Are you currently in O.T.? ☐ Yes ☐ No

Do you use any braces? ☐ Yes ☐ No

If yes, what areas do you have braces for _____

_____

Have you ever been given injections to treat pain? ☐ Yes ☐ No

If yes, where in your body and when? _____

_____

Check the box of any medications that you are taking or have tried in the past

- ☐ Atenolol (Tenormin)
- ☐ Clonidine (Catapress)
- ☐ Fludrocortisone (Florinef)
- ☐ Ivabradine (Corlanor)
- ☐ Metoprolol (Toprol)
- ☐ Midodrine (Proamatine)
- ☐ Nadolol (Corgard)
- ☐ Northera (Droxidopa)
- ☐ Propranolol (Inderal)
- ☐ Pyridostigmine (Mestinon)

- ☐ Adderall (dextroamphetamine)
- ☐ Alprazolam (Xanax)
- ☐ Amitriptyline (Elavil)
- ☐ Botox
- ☐ Clonazepam (Klonopin)
- ☐ Diazepam (Valium)
- ☐ Duloxetine (Cymbalta)
- ☐ Gabapentin (Neurontin)
- ☐ Fentanyl (Duragesic)
- ☐ Hydrocodone (Vicoden)
- ☐ Lorazapma (Ativan)
- ☐ Low dose naltrexone (LDN)

- [ ] Lyrica (Pregabalin)
- [ ] Medical Marijuana
- [ ] Methylphenidate (Ritalin)
- [ ] Morphine
- [ ] Oxycontin (Oxycodone)
- [ ] Opana (Oxymorphone)
- [ ] Nortriptyline (Pamelor)
- [ ] Nucynta (Tapentadol)
- [ ] Savella (Milnacipran)
- [ ] Straterra (atomoxetine)
- [ ] Topiramate (Topamax)
- [ ] Tramadol (Ultram)
- [ ] Valproic acid (Depakote)
- [ ] Venlafaxine (Effexor)
- [ ] Vyvanse (lisdexamfetamine)

Check any of these non medication treatments you have used

- [ ] Acupuncture
- [ ] Chiropractic
- [ ] Compression stockings
- [ ] Exercise
- [ ] Elevating head of bed
- [ ] Hypnosis
- [ ] IV fluids
- [ ] Massage
- [ ] High salt intake
- [ ] Gluten-free diet
- [ ] Low histamine diet
- [ ] Yoga