



Advanced Pediatric Cardiology, PLLC

Dysautonomia Clinic

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POTS / Dysautonomia Intake Form

Patient name: _____ Date of birth: _____

Please check all items that apply. This information helps us understand your symptoms and coordinate your care.

1. Ongoing symptoms

Heart, circulation & breathing

- | | |
|---|--|
| ☐ Tachycardia (fast heartbeat) | ☐ Palpitations (pounding chest) |
| ☐ Chest discomfort / chest pain | ☐ Shortness of breath |
| ☐ Dizziness / lightheadedness | ☐ Fainting / blackouts |
| ☐ Acrocyanosis (red/blue legs when standing) | ☐ Skin mottling |

Energy, neurological & sensory

- | | |
|--|---|
| ☐ Extreme fatigue / physical weakness | ☐ Exercise intolerance |
| ☐ Headaches | ☐ Brain fog |
| ☐ Tremors / shakiness | ☐ Visual disturbances (blurred or tunnel vision) |
| ☐ Tingling in hands / feet | ☐ Poor sleep (insomnia / sleep disturbances) |

Gastrointestinal, autonomic & other

- | | |
|--|--|
| ☐ Nausea / vomiting | ☐ Abdominal pain |
| ☐ Bloating | ☐ Bladder dysfunction |
| ☐ Temperature intolerance | ☐ Excessive sweating |
| ☐ Hypermobility | |

2. Recent medical history or events

- | | |
|--|---|
| ☐ Hypothalamic-pituitary-adrenal (HPA) axis dysfunction | ☐ Autoimmune disorders |
| ☐ Mitochondrial diseases | ☐ Mononucleosis (EBV) |
| ☐ Lyme disease | ☐ Anemia |
| ☐ Diabetes | ☐ Recent injuries |
| ☐ Accidents | ☐ Pregnancy / delivery |
| ☐ Prolonged illness | |

3. Previously diagnosed conditions

- | | |
|---|---|
| ☐ Irritable bowel syndrome (IBS) | ☐ Chronic fatigue syndrome |
|---|---|

3. Previously diagnosed conditions (continued)

☐ Fibromyalgia

☐ Epstein-Barr virus (EBV)

☐ Ehlers-Danlos syndrome (EDS)

☐ Mast cell activation syndrome (MCAS)

☐ Chiari malformation

If EDS: Was genetic testing performed?

☐ Yes

☐ No

☐ Unsure

If yes, where? _____

4. Current medications and therapies

☐ IV hydration

☐ IV immunoglobulin (IVIG)

☐ Sleep therapy

☐ Physical therapy

☐ Psychotherapy

☐ Stimulants

☐ Beta blockers

☐ SSRIs / benzodiazepines

5. Specialists involved in your care

Please list specialists to help coordinate communication among your care team.

Provider name	Specialty	Medications prescribed	Phone number

6. Additional vitamins and over-the-counter (OTC) medications

Include items not listed above.

Medication / supplement name	Dose and frequency

Patient / parent / guardian signature: _____ Date: _____