My Heart Cardiology

POTS Patient History Form

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Patient's Details

Full Name:

Date of Birth: | Medicare number:

Phone/Mobile: | Address:

History

Onset of symptoms date:

Self-description of symptoms:

Medical history preceding symptoms:

Family history:

Current Medications

Please include all prescribed medications, OTC, current supplements, and anything that has worked the best:

Common Symptoms

- ☐ Brain fog
- ☐ Post exertional malaise
- ☐ Light-headedness
- ☐ Palpitations
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Tingling or pain in fingers/feet
- ☐ Bladder problems (difficulty urinating)
- ☐ Bowel problems
- ☐ Gait disturbance (walking changes)
- ☐ Reflux or swallowing difficulties
- ☐ Lower limb swelling
- ☐ New tremor

Hypermobility Questionnaire

Can you now [or could you ever] place your hands flat on the floor without bending your knees?	☐Yes ☐No
Can you now [or could you ever] bend your thumb to touch your forearm?	☐Yes ☐No
As a child, did you amuse your friends by contorting your body into strange shapes or could you do the splits?	☐Yes ☐No
As a child or teenager, did your kneecap or shoulder dislocate on more than one occasion?	☐Yes ☐No
Do you consider yourself "double-jointed"?	☐Yes ☐No

Patient's Signature

Name:

Date: Signature:

Using Saved Drawing Signature | Using Saved E-Signature

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