Patient ID: Today's Date: I. Major Complaints and Duration: 1. Do you have any major autonomic complaints? Yes \square No \longrightarrow if No, skip to question 8. 2. Please list your three main symptoms: a. b. c. 3. How frequent are your symptoms? ☐ Rare Infrequent Frequent 4. How severe are your symptoms? ☐ Moderate ☐ Severe Mild \square < 1 year 5. How long have you had your symptoms? $\square > 1$ year \square < 1 month 6. Are your symptoms getting better or worse? ☐ No Change ☐ Better ☐ Worse 7. Does anybody in your family have similar symptoms? Yes No If Yes, who: II. Lightheadedness and Dizziness: 8. Do you experience spells of lightheadedness or dizziness? \(\pri \) Yes \square No \longrightarrow if No, skip to question 13. 9. How frequent are your symptoms? Rare ☐ Infrequent ☐ Frequent 10. How severe are your symptoms? Mild ☐ Moderate ☐ Severe 11. How long have you had your symptoms? $\square < 1$ month \square < 1 year $\square > 1$ year 12. Do your symptoms get worse during or after any of the following conditions? a. Standing for a long time? Yes No b. After a meal? Yes No c. After a hot bath, shower or sauna? ☐ Yes □ No d. With alcohol intake? Tyes e. After physical exertion or exercise? \square Yes No f. Being in a crowded environment (e.g. shopping mall)? Tyes No g. With emotions e.g. fear, anger, seeing blood, violent scenes etc? Yes No h. During menstrual cycle? Yes □ No i. During menstrual period? Yes □ No

Autonomic Symptoms Questionnaire (GE72)

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Autonomic Symptoms Questionnaire (GE72)

Patient ID: S
13. Have you ever fainted? Yes No
14. Have you ever lost consciousness? ☐ Yes ☐ No → if No, skip to question 18.
15. Do you know that you will faint or have a spell?
16. Are your spells or faints associated with any of the following?
a. Increased heart rate / palpitations?
b. Headache/migraine?
c. Memory loss?
d. Dizziness, lightheadedness? Yes No
e. Nausea or vomiting? Yes No
f. Blurred vision?
g. Feeling of weak?
h. Hot flushes?
i. Stomach pain?
j. Feeling anxious and nervous? Yes No
k. Swimming and spinning sensation? Yes No
l. Clammy, cold skin?
m. Hearing sounds or voices?
n. Breathing difficulty? Yes No
o. Feeling that you do not have enough air? Yes No
17. Can you abort your spell when you lie down or sit down? Yes No
18. Do you suffer from headache? Yes No
19. Do you suffer from migraine? \[\subseteq Yes \] No
III. Vasomotor and Secretory Symptoms:
20. What is the usual temperature of your hands?
21. What is the usual temperature of your feet? Normal Warm Cold
22. Is your sweating normal, reduced or increased? Normal Reduced Increased

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Autonomic Symptoms Questionnaire (GE72)

Patient ID: S
23. Where is your sweating increased or reduced? NA Hands Feet Other 24. Do you have dry eyes or dry mouth? Yes No
25. Do you have flushing of your face? Yes No
IV. Gastrointestinal Symptoms
26. Do you have normal bowel movement, constipation or diarrhea? ☐ Normal ☐ Constipation ☐ Diarrhea 27. Do you suffer from bloating or pain after meal? ☐ Yes ☐ No
28. Did your weight change within the last 6 months?
29. Are you on special diet? Yes No
V. Bladder and Sexual Symptoms
30. Do you have any difficulty with urination? ☐ Yes ☐ No
31. Do you have incontinence or retention? No Incontinence Retention
32. Has your sexual behavior changed over last 6 months? Yes No
33. Do you suffer from impotence? Yes No
34. Do you feel pain during intercourse? Yes No
VI. Chronic Pain
35. Do you suffer from chronic pain in your limbs? ☐ Yes ☐ No, skip to question 39.
36. Where do you have pain? Arms Legs Feet
37. Which side is affected more? Right Left Both
38. How long have you exhibited these symptoms? $\square < 1 \text{ month}$ $\square < 1 \text{ year}$ $\square > 1 \text{ year}$
39. Do you have any burning, tingling or pricking? ☐ Yes ☐ No → if No, skip to question 46.
40. Are your symptoms worse on the right or left limb? ☐ No ☐ Right ☐ Left
41. How severe are your symptoms? Mild Moderate Severe
42. How did your symptoms start?
43. Have you been operated on for your symptoms? Yes No

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Autonomic Symptoms Questionnaire (GE72)

Patient ID: S
44. Has the sensation-affected limb changed over the past 6 months?
45. Are your symptoms same, getting better or getting worse? Same Better Worse
46. What is the color of your skin on your hands and fingers?
47. What is the color of your skin on your feet and toes? Normal White
48. Are your symptoms better in cold or heat? \[\Bar{NA} \] \[\Bar{Cold} \] \[\Bar{Heat} \]
49. Do you have any numbness in your hands or feet? Yes No