D:\Users\jcaldous\AppData\Local\Microsoft\Windows\INetCache\Content.MSO\F66F8832.tmp**Orthostatic Hypotension Symptom Questionnaire**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ID NUMBER: |  |  |  |  |  |  |  |  | FORM CODE: | O | S | Q |  | DATE: 10/19/2021  Version 1.0 |

### ADMINISTRATIVE INFORMATION

0a. Completion Date: // 0b. Staff ID:

Month Day Year

**Instructions:** *The form is completed for all participants who agree to participate in the Orthostatic Hypotension ancillary study.*

**"We would like to ask you questions about symptoms you have experienced in the past 30 days during the process of standing up. On a scale from 1 to 5, where 1 represents “never” and 5 represents “every time you stand without exception”, please rate how often you experience the following:"**

**A. Symptom Assessment**

1. Light-headedness

Never 1

Rarely 2

Sometimes 3

Often 4

Every time 5

2. Dizziness

Never 1

Rarely 2

Sometimes 3

Often 4

Every time 5

3. Fainting:

Never 1

Rarely 2

Sometimes 3

Often 4

Every time 5

4. Black out:

Never 1

Rarely 2

Sometimes 3

Often 4

Every time 5

5. Imbalance:

Never 1

Rarely 2

Sometimes 3

Often 4

Every time 5

**B. Fall History**

6. Have you experienced a fall in the past year?

Yes Y

No N **Skip to item 8**

7. How many times did you fall in the past year?

*For each fall reported in the past year, complete items* ***a and b*** *in the table below.*

|  |  |  |
| --- | --- | --- |
|  | 1. What date did this fall occur? (approximate if unsure) | 1. Did this fall result in a broken bone, an urgent care or emergency room visit, or a hospitalization? |
| 1. 1st fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 2nd fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 3rd fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 4th fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 5th fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 6th fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 7th fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 8th fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 9th fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |
| 1. 10th fall | \_\_\_ / \_\_\_ / \_\_\_\_\_  mm dd yyyy | □Y Yes □N No |

8. Since turning age 65 have you ever broken a bone, visited an urgent care/emergency room, or been hospitalized because of a fall?

Yes Y

No N