ORTHOSTATIC HYPOTENSION QUESTIONNAIRE (OHQ)

Patient Instructions: We are interested in measuring the symptoms that occur because of your problem with low blood pressure (orthostatic hypotension) and the degree that those symptoms may interfere with your daily activity. It is important that we measure the symptoms that are due ONLY to your low blood pressure, and not something else (like diabetes or Parkinson's disease). Many people know which of their symptoms are due to low blood pressure. Some people who have recently developed problems with low blood pressure may not easily distinguish symptoms of low blood pressure from symptoms caused by other conditions. In general, symptoms of your low blood pressure problem will appear either upon standing or after you have been standing for some time, and will usually improve if you sit down or lie down. Some patients even have symptoms when they are sitting which might improve after lying down. Some people have symptoms that improve only after sitting or lying down for quite some time.

Please answer the questions below keeping in mind that we want to know only about those symptoms that are from your problem with low blood pressure.

OH SYMPTOM ASSESSMENT (OHSA)

Please tick the number on the scale that best rates how severe your symptoms from low blood pressure have been on the average over the past week. You should respond to every symptom. If you do not experience the symptom, circle zero (0). YOU SHOULD RATE ONLY THE SYMPTOMS THAT ARE DUE TO YOUR LOW BLOOD PRESSURE PROBLEM.

None	**1. Dizziness, lightheadedness, feeling faint, or feeling like you might black out**										Worst possible
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
None	**2. Problems with vision (blurring, seeing spots, tunnel vision, etc.)**										Worst possible
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
None	**3. Weakness**										Worst possible
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
None	**4. Fatigue**										Worst possible
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
None	**5. Trouble concentrating**										Worst possible
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
None	**6. Head and neck discomfort**										Worst possible
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

OH DAILY ACTIVITY SCALE (OHDAS)

We are interested in how the low blood pressure symptoms that you experiences affect daily life. Please rate each item by ticking the number that best represents how much on the average the activity has been interfered with over the past week by the low blood pressure symptoms you have experienced. If you cannot do the activity for reasons other than low blood pressure, please check the box at right.

No interference	**1. Activities that require standing for a short time**							☐ Cannot do for other reasons				Total interference
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
No interference	**2. Activities that require standing for a long time**							☐ Cannot do for other reasons				Total interference
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
No interference	**3. Activities that require walking for a short time**							☐ Cannot do for other reasons				Total interference
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
No interference	**4. Activities that require walking for a long time**							☐ Cannot do for other reasons				Total interference
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	