**About Dr. Santa Maria’s experience with POTS and the treatment Dysautonomia**

* Dr. Santa Maria is very familiar with patients all along the Dysautonomia spectrum.
* He provides in-office saline therapy for preventative measures.
* His goals are to lessen emergency room visits and hospital stays with unnecessary testing and miscommunication with physicians who are unfamiliar with POTS/Dysautonomia.
* He is actively working on research about the disease and conducting his own studies, as well as working on a tilt-table strength training therapy for in-office patients.
* He has worked with POTS patients to test the effectiveness of off-label medication for the different symptoms of POTS.

**Are you experiencing any of the following symptoms?**

|  |  |
| --- | --- |
| Fainting |  |
| GI Motility Issues/Gastroparesis |  |
| Racing Pulse/Tachycardia |  |
| Dry Skin/Eyes |  |
| Vertigo |  |
| Vomiting |  |
| Dizziness |  |
| Nausea |  |
| Adhesions |  |
| Low/High BP |  |
| Visual Disturbances |  |
| Joint Pain |  |
| Fatigue |  |
| Dizziness |  |
| Migraines |  |
| Hypermobility (can you bend the thumb to the wrist?) |  |

**Have you recently?**

|  |  |
| --- | --- |
| Had Mono? |  |
| Been in a car crash? |  |
| Had a baby? |  |
| Had surgery? |  |
| Gone through a long period of illness? |  |

**Have you ever been diagnosed with?**

|  |  |
| --- | --- |
| Irritable Bowel Syndrome? |  |
| Chronic Fatigue Syndrome? |  |
| Fibromyalgia? |  |
| Epstien Bar Virus? |  |
| Ehlers-Danlos? |  |
| Mast Cell? |  |
| Chiari Malformation? |  |

**Do you currently now or have you received/used in the past:**

|  |  |
| --- | --- |
| IV Saline Therapy? |  |
| Stimulants (such as Adderall?) |  |
| Beta Blockers? |  |

**What other physicians are you currently seeking treatment from?**

|  |  |
| --- | --- |
| Specialty | Name |
|  |  |
|  |  |
|  |  |

**Please bring to your appointment:**

|  |
| --- |
| 1. A summary of your medical history by age. |
| 1. A list of any/all medication and dosages. |
| 1. A summary of your family medical history. |
| 1. Please pre-send by fax or bring print copies of your medical history for (at least) the last year. |
| 1. A list of any allergies to medication, food, or environments. |
| 1. A list of questions or concerns about your condition that you would like answered. |
| 1. Any research that you feel may be relevant to your condition. |