

Bateman Horne Center of Excellence

24 S. 1100 E. Suite 205  
Salt Lake City, Utah 84102

**Orthostatic Intolerance\* Questionnaire (OIQ)**  
**Orthostatic Intolerance\* Daily Activities Scale (OIDAS)**

We are interested in how orthostatic intolerance symptoms might affect your daily life. Please rate each item by checking the number that best represents how much the activity has been interfered with *on the average* over the past week by the orthostatic intolerance symptoms you experienced.

If you cannot do the activity for reasons other than ME/CFS or orthostatic intolerance, please check the box at the right.

1. Standing short time

No interference <input type="checkbox"/> 0	1	2	3	4	5	6	7	8	9	10 Complete Interference <input type="checkbox"/>	Cannot do for other reasons <input type="checkbox"/>
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2. Standing long time

No interference <input type="checkbox"/> 0	1	2	3	4	5	6	7	8	9	10 Complete Interference <input type="checkbox"/>	Cannot do for other reasons <input type="checkbox"/>
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3. Walking short time

No interference <input type="checkbox"/> 0	1	2	3	4	5	6	7	8	9	10 Complete Interference <input type="checkbox"/>	Cannot do for other reasons <input type="checkbox"/>
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4. Walking long time

No interference <input type="checkbox"/> 0	1	2	3	4	5	6	7	8	9	10 Complete Interference <input type="checkbox"/>	Cannot do for other reasons <input type="checkbox"/>
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\*We have substituted the word “intolerance” for “hypotension” in this questionnaire

**OIDAS + OISA = OIQ**

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**Orthostatic Intolerance\* Questionnaire (OIQ)**  
**Orthostatic Intolerance\* Symptom Assessment (OHSA)**

Please check the number on the scale that best rates how severe your symptoms from ME/CFS or orthostatic intolerance have been *on the average* over the past week. Please respond to every symptom. If you do not experience the symptom, circle zero (0).

1. Dizziness, lightheadedness, feeling faint, or feeling like you might blackout.

NONE 0 <input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10 WORST POSSIBLE <input type="checkbox"/>
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2. Problems with vision (blurring, seeing spots, tunnel vision, etc.)

NONE 0 <input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10 WORST POSSIBLE <input type="checkbox"/>
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3. Weakness

NONE 0 <input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10 WORST POSSIBLE <input type="checkbox"/>
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4. Fatigue

NONE 0 <input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10 WORST POSSIBLE <input type="checkbox"/>
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5. Trouble concentrating.

NONE 0 <input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10 WORST POSSIBLE <input type="checkbox"/>
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6. Head/neck discomfort

NONE 0 <input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10 WORST POSSIBLE <input type="checkbox"/>
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\*We have substituted the word “intolerance” for “hypotension” for the use of this questionnaire

**OIDAS + OISA= OIQ**

The Orthostatic Hypotension Questionnaire (OHQ): validation of a novel symptom assessment scale.

Kaufmann H1, Malamut R, Norcliffe-Kaufmann L, Rosa K, Freeman R Clin Auton Res. 2012 Apr;22(2):79-90. doi: 10.1007/s10286-011-0146-2. Epub 2011 Nov 2.