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Transthyretin Amyloidosis

Cardiomyopathy Questionnaire

Patient Name _____

Date / /
(mm/dd/yyyy)

Symptoms:

- 1** Do you suffer from shortness of breath?
 Never Some of the time Most of the time Always

- 2** If yes, what level of activity makes you short of breath?
 Two flights of stairs (20 steps) One flight of stairs (10 steps) Walking around your home
 At rest Not applicable

- 3** Do you have swelling (fluid retention) in your legs or other areas (waist, hands)?
 Never Some of the time Most of the time Always

- 4** Do you need to prop your head up to breathe comfortably for sleeping?
 Never Some of the time Most of the time Always

- 5** If yes, how many pillows do you use (how high do you prop your head-up)?
 2 pillows 3 pillows 4 pillows Sleep fully upright (i.e., in a chair)
 Not applicable

- 6** Do you wake up in the middle of the night unable to breathe?
 Never Some of the time Most of the time Always

- 7** Do you experience chest pain?
 Never Some of the time Most of the time Always

- 8** Do you feel full/bloated easily after meals?
 Never Some of the time Most of the time Always

Continued »

Symptoms: (continued)

9 Do you feel lightheaded or faint when standing up and/or walking?

- Never Some of the time Most of the time Always
-

10 Have you ever fainted or passed out (lost consciousness)?

- No Yes
-

Past Medical History:

11 Do you have a history of heart failure?

- No Yes
-

12 Do you have a history of atrial fibrillation or atrial flutter (irregular or racing heart beat)?

- No Yes
-

13 Do you have a pacemaker?

- No Yes
-

14 Do you have, or have you ever had aortic valve stenosis (aortic stenosis)?

- No Yes
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