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Transthyretin Amyloidosis

Patient 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 excessively tired/lethargic?

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

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

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

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

- No Yes
-

12 Do you experience palpitations/heart racing?

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

13 Do you experience abdominal (stomach) pain?

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

14 Do you experience constipation?

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

15 Do you experience diarrhea/loose or watery bowel movements?

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

16 Do you experience blurred vision (even with corrective eye-wear such as glasses or contact lenses)?

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

17 Do you experience sexual dysfunction?

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

18 Are you unable to differentiate hot from cold (for example, when getting in the shower or bath)?

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

19 Are you unable to sweat even when you are hot?

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

20 Do you feel numbness, tingling, burning or prickling sensation in the hands or feet?

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

Continued »

Symptoms: (continued)

21 Do you have difficulty with balance (for example, in the shower or at night time or other times)?
 Never Some of the time Most of the time Always

22 Have you experienced unintentional weight loss?
 No Yes

23 Do you require an aid to walk and/or move around?
 No Cane Walker Wheelchair

24 Do your hands or arms ever 'fall asleep', go 'dead' or get numb during the night?
 Never Some of the time Most of the time Always

Past Medical History:

25 Do you have a history of heart failure?
 No Yes

26 Do you have a history of atrial fibrillation or atrial flutter (irregular or racing heart beat)?
 No Yes

27 Do you have a pacemaker?
 No Yes

28 Do you have, or have you ever had aortic valve stenosis (aortic stenosis)?
 No Yes

29 Have you ever had a stroke or transient ischemic attack (TIA or mini-stroke)?
 No Yes

30 Do you have a history of carpal tunnel syndrome?
 No Yes

Continued »

Past Medical History: (continued)

31 Have you ever been diagnosed with neuropathy?

- No Yes
-

32 Do you have, or have you ever had spinal stenosis (lumbar, cervical or other)?

- No Yes
-

Family History:

33 Do you have a family history of amyloidosis?

- No Yes
-

34 If yes, do you know what type of amyloidosis your family member had?

- AL (light chain) Transthyretin wild-type (ATTR, age-related)
 Transthyretin hereditary (ATTR, mutant or familial) Uncertain None
-

35 What is your family heritage or background?

- Scandinavian Asian Portuguese or Southern European
 United Kingdom African-Caribbean South American
 Other _____ Prefer not to answer
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