Clear All

Print

Save

Email

Transthyretin Cardiomyopathy

Patient Questionnaire (Standard)

Patient Name ______________________ **Date** ___/___/_____
(mm/dd/yyyy)

Symptoms:

1 **Do you feel full/bloated easily after meals?**

☐ Never ☐ Some of the time ☐ Most of the time ☐ Always

2 **Do you feel excessively tired/lethargic?**

☐ Never ☐ Some of the time ☐ Most of the time ☐ Always

3 **Do you experience abdominal (stomach) pain?**

☐ Never ☐ Some of the time ☐ Most of the time ☐ Always

4 **Do you experience constipation?**

☐ Never ☐ Some of the time ☐ Most of the time ☐ Always

5 **Do you experience diarrhea/loose or watery bowel movements?**

☐ Never ☐ Some of the time ☐ Most of the time ☐ Always

6 **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

7 **Do you experience sexual dysfunction?**

☐ Never ☐ Some of the time ☐ Most of the time ☐ Always

8 **Have you experienced unintentional weight loss?**

☐ No ☐ Yes

9 **Do you require an aid to walk and/or move around?**

☐ No ☐ Cane ☐ Walker ☐ Wheelchair

Continued »

Family History:

10 **Do you have a family history of amyloidosis?**

☐ No ☐ Yes

---

11 **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

---

12 **What is your family heritage or background?**

☐ Scandinavian ☐ Asian ☐ Portuguese or Southern European

☐ United Kingdom ☐ African-Caribbean ☐ South American

☐ Other ____________________ ☐ Prefer not to answer