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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