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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 experiences unintentional weight loss?
 Yes No

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

Continued »

Family History

32 Do you have a family history of amyloidosis?

- No Yes
-

33 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
-

34 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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