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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