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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 experienced unintentional weight loss?
☐ No ☐ Yes

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

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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