WORKING COPY

ID { WISE ID_____

Name Code: _____

SQDAT Date: ____/____/____
mm dd yy

When Administered in Protocol ADMIN
Ø ( ) pre-angio
1 ( ) post-angio

WISE
SYMPTOM HISTORY QUESTIONNAIRE

1. What problems or complaints did you experience that eventually led to your having this evaluation? Check all that apply:

		Yes 1	No 0
1.1	Abdominal pain ABPAN	( )	( )
1.2	Arm pain or shoulder pain ARPAN	( )	( )
1.3	Back pain BKPAN	( )	( )
1.4	Chest pain CHPAN	( )	( )
1.5	Chest pressure CHPRS	( )	( )
1.6	Chest tightness CHTIT	( )	( )
1.7	Chest discomfort (heaviness, burning, tenderness) CHDIS	( )	( )
1.8	Cough COUGH	( )	( )
1.9	Dizziness, lightheadedness DIZZY	( )	( )
1.10	Feel lousy/general blahness LOUSY	( )	( )
1.11	Headache HEADA	( )	( )
1.12	Heartburn/indigestion/stomach problem HBURN	( )	( )
1.13	Impending doom I DOOM	( )	( )
1.14	Jaw pain JAWPN	( )	( )
1.15	Loss of consciousness/fainting LCONS	( )	( )
1.16	Nausea/vomiting NAUSE	( )	( )
1.17	Neck pain NKPAN	( )	( )
1.18	Numbness/tingling in arm or hand NUMBA	( )	( )
1.19	Palpitations/rapid heart rate PALPI	( )	( )
1.20	Shortness of breath/difficulty breathing SHORT	( )	( )
1.21	Sweating SWEAT	( )	( )
1.22	Weakness/fatigue/faintness WEAKF	( )	( )
1.23	Other POTYN	( )	( )

Specify: POTSP

2. Before seeing your physician for the first time for your symptoms, did you take any action or do anything for these problems or complaints? Check all that apply:

		Yes 1	No 0
2.1	Drank alcohol ALCOH	( )	( )
2.2	Took antacid ANTAC	( )	( )
2.3	Took aspirin/other pain medication ASPIR	( )	( )
2.4	Took nitroglycerin NITRO	( )	( )
2.5	Took tranquilizer or relaxing drug TRANQ	( )	( )
2.6	Took other medication, Specify OTMED OTMDS	( )	( )
2.7	Talked to coworker COWRK	( )	( )
2.8	Talked to doctor DOCTR	( )	( )
2.9	Talked to family member FMILY	( )	( )
2.10	Talked to friend FRND	( )	( )
2.11	Talked to hospital personnel HSPPE	( )	( )
2.12	Talked to nurse NURSE	( )	( )
2.13	Talked to other person, Specify: OTPER OTPSP	( )	( )
2.14	Accepted symptoms/situation ACCEP	( )	( )
2.15	Did nothing to cope/respond to symptoms DNOTH	( )	( )
2.16	Disengaged self from symptoms by doing/thinking something else DISEN	( )	( )
2.17	Ignored symptoms IGNOR	( )	( )
2.18	Redefined symptoms/situation as not threatening REDEF	( )	( )
2.19	Rested/stopped activity RESTS	( )	( )
2.20	Waited to see what would happen WAITS	( )	( )
2.21	Other activity OTACT Specify: OTACS	( )	( )

3.1. In the last 12 months have you felt any uncomfortable sensation in any of the following locations? (Please do not include symptoms you have because of a stomach problem for which you have received medical care.)

Check all positions that apply and check specific side, for example, left, center or right.

CHEST ( ) Chest----> CHESL ( ) Left CHESC ( ) Center CHESR) Right
NECK ( ) Neck----> NECKL ( ) Left NECKC ( ) Center NECKR) Right
BACK ( ) Back----> BACKU ( ) Upper BACKM ( ) Middle BACKL) Lower
SHDR ( ) Shoulder----> SHDLL ( ) Left SHDLR ( ) Right SHDLB ( ) Both
ARM ( ) Arm----> ARML ( ) Left ARMR ( ) Right ARMB ( ) Both
HAND ( ) Hand----> HANDL ( ) Left HANDR ( ) Right HANDB ( ) Both
JAW ( ) Jaw----> JAWL ( ) Left JAWR ( ) Right JAWB ( ) Both
STROA ( ) Throat
SESOP ( ) Esophagus
SSTOM ( ) Stomach
SPOTH ( ) Other, Specify: PSOSP
ANONE ( ) None of the above----->Skip to Question 4 on Page 5

3.2 When was the first time you ever experienced this feeling? (Please give an approximate date)

FIRST

3.3 Has your doctor told you that this sensation is related to your heart?

1 ( ) Yes 0 ( ) No DRSEN

3.4 On average, how often do you experience this feeling?

3.4.1 Check the interval. INTER

0 ( ) Daily 1 ( ) Weekly 2 ( ) Monthly 3 ( ) Yearly

3.4.2 Within that interval, check the number of times you experience this feeling. NDEXP

( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9+

3.5 How long does it usually last? Check one only: LASTH

1 ( ) Less than one minute
2 ( ) 1 - 5 minutes
3 ( ) 5 - 15 minutes
4 ( ) 15 - 30 minutes
5 ( ) 30 - 60 minutes
6 ( ) More than 60 minutes

3.6 What causes this sensation? Please check all that apply:

			Yes	No
			1	0
LBODE	3.6.1	Lower body exertion (such as climbing stairs or walking up a hill)	( )	( )
UBODE	3.6.2	Upper body exertion (such as putting away groceries or cooking)	( )	( )
WBODE	3.6.3	Whole body exertion (such as carrying a child or vacuuming)	( )	( )
SEXAC	3.6.4	Sexual activity	( )	( )
EMSTR	3.6.5	Strong emotions or stressful situations	( )	( )
HOTCO	3.6.6	When it's very hot or very cold	( )	( )
MEALS	3.6.7	During or after meals	( )	( )
REST	3.6.8	Nothing at all (it happens at rest)	( )	( )
UNCER	3.6.9	Uncertain	( )	( )
~~OTH~~	3.6.10	Other	( )	( )
OTCYN		Specify: OTCSP		

3.7 What usually relieves this uncomfortable sensation? (Check all that apply)

STOPA ( ) Stopping the activity that brought it on
RREST ( ) Rest
RNITR ( ) Nitroglycerine
RMEDS ( ) Medications for heartburn or acid stomach (i.e.,Tagamet or Mylanta)
OTRYN ( ) Other, Specify: ROTSP
RNOTH ( ) Nothing seems to relieve it

3.8 Using the scale below, check the level of intensity of this uncomfortable sensation:

IUSUA 3.8.1 At its usual level: ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5

IWORS 3.8.2 At its worst level: ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5

Code:

Level 1 - Tolerable, no relief needed
Level 2 - Tolerable, relieved with usual measures
Level 3 - Tolerable, not relieved with usual measures
Level 4 - Not tolerable, relieved with usual measures
Level 5 - Not tolerable, not relieved with usual measures

3.9 Please check the word or words that describe this uncomfortable sensation:

DDISC ( ) Discomfort DTGHT ( ) Tightness DINDG ( ) Indigestion DNAUS ( ) Nausea
DPAIN ( ) Pain DNUMB ( ) Numbness DCHOK ( ) Choking DSHRP ( ) Sharp/knife like
DPRSS ( ) Pressure DACHE ( ) Aching DBURN ( ) Burning DNONE ( ) None of the above

If none of those words describe your sensation, describe it in your own words:_____

NONED

3.10 Does this feeling ever:

		Yes	No
		1	0
WAKES	3.10.1 Wake you up from sleep?	( )	( )
BREAT	3.10.2 Change when you take a deep breath?	( )	( )
CPRES	3.10.3 Change when you press on it?	( )	( )
CPOST	3.10.4 Change when you change positions?	( )	( )

3.11 Have you sought or are you seeking medical care because of this uncomfortable sensation?

1 ( ) Yes 0 ( ) No MCARE

4. Do you currently experience:

4.1 Difficulty breathing? DBREA 1 ( ) Yes 0 ( ) No

↓

4.1.1 Does it occur during mild physical exertion (walking one block on level ground)? DPHYS 1( ) Yes 0 ( ) No

4.1.2 Does it accur at rest? DREST 1( ) Yes 0 ( ) No

FFAT1

4.2 Feelings of fatigue with low level exertion? 1( ) Yes 0 ( ) No

EOTYN

4.3 Other symptoms not yet mentioned? 1( ) Yes 0 ( ) No
Specify: EOTSP_____

5. Has your doctor ever told you that you have any of these problems?

		Yes	No
		1	0
XHERN	5.1 Hiatal hernia	( )	( )
XREFL	5.2 Esophageal reflux	( )	( )
XULCR	5.3 Ulcer (gastric, peptic, duodenal)	( )	( )
XGALL	5.4 Gallbladder disease	( )	( )