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: POTSY

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 OTMED medication, Specify 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 OTPER person, Specify: 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. NOEXP

( ) 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	( )	( )
~~OTHN~~	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 DTIGHT( ) 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

FFATI

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
X HERN	5.1 Hiatal hernia	( )	( )
X REFL	5.2 Esophageal reflux	( )	( )
X ULCR	5.3 Ulcer (gastric, peptic, duodenal)	( )	( )
X GALL	5.4 Gallbladder disease	( )	( )