Cardiac Ablation PROM (C-CAP)

Draft Version (pre-validation)

Arrhythmia Questionnaire – Before your Operation

Please complete the following and answer **ALL** of the questions as accurately as possible.

1) Please tick **ONE** box which best describes what you expect to happen to the **FREQUENCY** of the attacks of your palpitations / fast or irregular heartbeats (i.e. how OFTEN they occur), **after you have recovered from the procedure;**

My palpitations / fast or irregular heartbeats will: (please tick one)

Stop	
Become less frequent	
Will not change	
Will become more frequent	
I do not have palpitations / fast or irregular heartbeats	

2) Please tick **ONE** box which best describes what you expect to happen to the **LENGTH** of the attacks of your palpitations / fast or irregular heartbeats (i.e. how LONG they last), **after you have recovered from the procedure**;

My palpitations / fast or irregular heartbeats will: (please tick one)

Stop	
Become shorter	
Not change	
Become longer	
I do not have palpitations / fast or irregular heartbeats	

3) Please tick **ONE** box in **EACH** column which best describes what you expect to happen to your **tiredness and breathlessness** after you have recovered from the procedure**:**

	Please tick one
I will stop feeling tired	
I will feel less tired	
I will feel no different (tired)	
I will feel more tired	
I do not feel tired	

	Please tick one
I will stop feeling breathless	
I will feel less breathless	
I will feel no different (breathless)	
I will feel more breathless	
I do not feel breathless	

4) Is this your first ablation procedure? Yes☐ No ☐

5) If No, please state how many you have had previously (not including this one) _____

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The following questions are related to your condition and symptoms.

6) Please circle the numbers below that most accurately indicate the severity of each symptom you have had **within the last 30 days**. Please circle **ONE** number for **EVERY** symptom. If you do not have the symptom please circle 0 (None).

	0 None	1 Mild	2 Moderate	3 Severe
Palpitations / fast or irregular heartbeats	0	1	2	3
Heart flutters	0	1	2	3
Extra heart beats / missed heart beats	0	1	2	3
Fatigue / no energy	0	1	2	3
Dizziness / light-headedness / feeling faint	0	1	2	3
Hard to catch breath / short of breath	0	1	2	3
Chest pressure as heart is racing	0	1	2	3
Headache / migraine	0	1	2	3
Trouble concentrating	0	1	2	3
Neck pounding / neck pain / neck discomfort	0	1	2	3
Passing out / fainting / blackouts	0	1	2	3
Trouble sleeping	0	1	2	3
Tiredness / sleepiness	0	1	2	3
Nausea / vomiting	0	1	2	3
Anxiety / fear / worry	0	1	2	3

7) How often do you usually get palpitations / fast or irregular heartbeats? Please tick one only

Never	Once a month or less	Several times a month	Several times a week	Several times a day
☐	☐	☐	☐	☐

8) How long do your episodes of palpitations / fast or irregular heartbeats **usually** last? Please tick one only.

Not Applicable	Less than 5 minutes	5 minutes to 1 hour	More than 1 hour but less than 12 hours	12 hours or more
☐	☐	☐	☐	☐

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9) Have your palpitations / fast or irregular heartbeats had any impact on the number of days you have attended work / school / college (including unpaid work, role as a carer and time spent job-seeking) **in the last 30 days**? If so, for how many days do you think it had an impact? (If this does not apply please tick "Not Applicable").

	No of Days (0-30)	Not applicable
Days you have missed at work / school / college		

10) Have your palpitations / fast or irregular heartbeats had any impact on your social activities **in the last 30 days**, and if so, for how many days do you think it has had an impact?

	No of Days (0-30)	Not applicable
Days you have had to cut down on your social activities		

11) Have your palpitations / fast or irregular heartbeats had any impact on the number of days you have been able to carry out your normal daily activities (including household duties) **in the last 30 days**? If so, for how many days do you think it has had an impact?

	No of Days (0-30)	Not applicable
Days you have been unable to carry out normal daily activities		

12) How many times have you needed to visit a GP / Hospital **within the last 30 days** (related to your palpitations / fast or irregular heartbeats)?

GP ☐ Hospital ☐

13) Please circle the number that most accurately indicates how you feel about the following statements. Please circle **ONE** number for **EVERY** statement. If you feel the statement does not apply to you please circle 0 (Not Applicable).

	0 Not Applicable	1 Agree Mildly	2 Agree Moderately	3 Agree Strongly
I worry that my palpitations/fast or irregular heartbeats will start	0	1	2	3
My everyday physical activities are limited	0	1	2	3
My palpitations have an impact on my own sport / leisure activities	0	1	2	3
I worry about the effect of my heart rhythm on my health	0	1	2	3
My palpitations / fast or irregular heartbeats interfere with my social activities	0	1	2	3
I am restricted in my travel / holiday plans	0	1	2	3
I am less confident due to my palpitations	0	1	2	3
My palpitations / fast or irregular heartbeats have an emotional / physical impact when I am driving	0	1	2	3
My palpitations have had a financial impact (e.g. time off work, extra childcare costs)	0	1	2	3
My palpitations have an impact on my family / friends	0	1	2	3

14) Do you normally take any medication for your palpitations / fast or irregular heartbeat?

Yes ☐ No ☐

15) If Yes, please tell us the name of the medications you take for your palpitations and the amount you take each day.

Name of medication	Amount each day (in mg)
_____	_____
_____	_____
_____	_____
_____	_____

16) If you currently take medication for your palpitations / fast or irregular heartbeats how desirable is it for you to reduce or stop taking this medication following your ablation?

Not applicable	Not important	Quite important	Very important
☐	☐	☐	☐

The following questions are related to your <u>GENERAL</u> health:

17) Have you been told by a doctor that you have any of the following? (Please tick all that apply)

Liver disease	☐	High blood pressure	☐
Other heart condition e.g. angina, heart attack or heart failure	☐	Cancer (within the last 5 years)	☐
Diabetes	☐	Leg pain when walking due to poor circulation	☐
Lung disease e.g. asthma, chronic bronchitis or emphysema	☐	Arthritis	☐
Kidney disease	☐	Depression	☐
Problems caused by stroke	☐	Diseases of the nervous system e.g. Parkinson's disease or multiple sclerosis	☐