

Cardiff Cardiac Ablation PROM (C-CAP1)

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) _____

Cardiff Cardiac Ablation PROM (C-CAP1)

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
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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cardiff Cardiac Ablation PROM (C-CAP1)

- 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?

	No of Days (0-30)	I do not attend work/ school/ college (✓)
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)
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)
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 an impact on my family / friends	0	1	2	3

Cardiff Cardiac Ablation PROM (C-CAP1)

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

Yes No

15) 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 GENERAL health:

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

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