

For Office Use Only

Patient ID: _____

Date of operation: _____

Hospital: _____

Date received: _____

CORONARY REVASCULARISATION OUTCOME QUESTIONNAIRE (CROQ-CABG)

INSTRUCTIONS: We are interested in finding out how you have been since the heart operation (**coronary artery bypass graft surgery**) you had 3 months ago. We would be grateful if you could help us by filling out this questionnaire. All of the information you provide is **COMPLETELY CONFIDENTIAL**. Please be sure to answer all questions.

1. During the past 4 weeks, how much were you bothered by each of the following problems related to your **heart condition**? (Please tick one box on each line.)

	A lot	Quite a bit	Moderately	A little	Not at all
Chest pain due to angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort in your chest due to angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina pain that radiates to other parts of your body (eg arms, shoulders, hands, neck, throat, jaw, back)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations (strong or irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. During the past 4 weeks, on average, how many times have you taken nitros (nitroglycerin tablets or spray) for your **chest pain, chest tightness or angina**? (Please tick only one box.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 or more times per day	1-3 times per day	3 or more times per week but not every day	1-2 times per week	Less than once a week	None over the past 4 weeks

3. During the past 4 weeks, have you had **chest pain, chest tightness or angina**:
(Please tick only one box.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At rest?	On exertion?	At rest and on exertion?	Not at all?

4. During the past 4 weeks, how much trouble has your **heart condition** caused you?
(Please tick only one box.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A lot	Quite a bit	Some	A little	None

5. The following questions ask about activities which you might do during a typical day. During the past 4 weeks, has your **heart condition** limited you in your usual daily activities? Please indicate whether your heart condition limits you a lot, limits you a little, or does not limit you at all in the activities listed below. (Please tick one box on each line.)

<u>ACTIVITIES</u>	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending, kneeling or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking half a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking one hundred yards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. The next questions ask about the impact of your **heart condition** on your family and friends and the extent to which it has interfered with your social activities. During the past 4 weeks, how often have you experienced the following as a result of your **heart condition**:
(Please tick one box on each line.)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Family or friends being overprotective toward you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling like you are a burden on others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling restricted in your social activities (like visiting with friends, relatives, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling worried about going too far from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. The next questions ask about your feelings about your **heart condition**. During the past 4 weeks, how often have you felt: (Please tick one box on each line.)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Worried about your heart condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried about doing too much or over-doing it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried that you might have a heart attack or die suddenly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried that your symptoms might return?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frightened by the pain or discomfort of your heart condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncertain about the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frustrated or impatient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
That your heart condition interfered with your enjoyment of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
That it was difficult to keep a positive outlook about your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
That it was difficult to plan ahead (eg vacations, social events, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. The next questions ask about problems related to your **heart condition**. During the past 4 weeks, how much of the time did you: (Please tick one box on each line.)

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have difficulty reasoning and solving problems, for example making plans, making decisions, learning new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forget, for example things that happened recently, where you put things or appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have difficulty doing activities involving concentration and thinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Since your heart operation, have you been re-admitted to hospital for an overnight stay for any reason to do with your **heart condition or heart operation**? Please give as many details as you can below.

No

Yes

Date of Admission	Name of hospital	Reason for hospital stay	Number of days
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. The next questions ask about problems you might have had **since your heart operation**. During the past 4 weeks, how much were you bothered by the following problems? If you did not have the problem, tick the last box "Not at all". (Please tick one box on each line.)

	A lot	Quite a bit	Moderately	A little	Not at all
Pain in your chest wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection in your chest wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness around your chest wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling around your chest wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising on your chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in your leg or arm wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other pain in your leg or arm due to your operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection in your leg or arm wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your leg or arm due to your operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising on your leg or arm where a vein was removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. The next question asks about how satisfied you are with your **heart operation**. How satisfied are you with the: (Please tick one box on each line.)

	Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
Results of your heart operation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information you were given about your heart operation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information you were given about how you might feel while recovering from your heart operation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Overall, how would you describe your **heart condition** now compared to before you had your heart operation? (Please tick one box.)

Much worse

A little worse

About the same

A little better

Much better

13. Has your recovery from your **heart operation** so far been: (Please tick one box.)

Slower than you
expected?

About what you
expected?

Faster than you
expected?

Did not know how
long it would take?

14. Are the results from your **heart operation**: (Please tick one box.)

Worse than you
expected?

About what you
expected?

Better than you
expected?

15. Is there anything else you would like to tell us about your **heart condition** or **heart operation** that is not covered in this questionnaire? If so, please write below.

Please check that you have answered all the questions on each page.

THANK YOU FOR YOUR HELP