

CORONARY REVASCULARISATION OUTCOME QUESTIONNAIRE (CROQ-CABG v2)

INSTRUCTIONS: We are interested in finding out about the problems you have with your heart. 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, 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

4. This question 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"/>

5. This question asks 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"/>

6. This question asks 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"/>
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"/>

7. This question asks 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"/>