Atrial fibrillation (AF) can have a significant impact on quality of life and your answers will help us build up a clearer picture of how patients waiting for ablation are currently feeling. Your answers are confidential and all data is held securely. Individual answers will not be reported.

Start Here:

1. What is your name and date of birth? _____

2. What is your sex? ☐ Male ☐ Female

3. Are you in AF all the time (persistent AF) or does it come and go (paroxysmal AF)

☐ All the time ☐ Comes and goes ☐ Not sure / unable to answer

4. What medications are you currently taking for your heart rhythm problem?

☐ beta blockers e.g bisoprolol, nebivolol, atenolol, metoprolol

☐ calcium channel blockers e.g. verapamil, diltiazem (Tildiem. Adizem, Dilzem)

☐ Digoxin

☐ Amiodarone

☐ Flecainide or Propafenone

☐ Sotalol

☐ None

5. Which of the following health conditions apply to you?

Do you have diabetes?	☐Yes	☐ No
Do you have heart failure?	☐Yes	☐ No
Have you ever had a stroke or mini stroke (TIA)?	☐Yes	☐ No
Have you been diagnosed with high blood pressure?	☐Yes	☐ No
Do you get cramps in your legs when you walk that go away when you stop /rest (peripheral vascular disease or peripheral artery disease)?	☐Yes	☐ No

6. Do you have any other health conditions which have a significant impact on your day-to-day quality of life? (Select ALL that apply)

☐Angina

☐Arthritis (that limits you)

☐Asthma/COPD

☐Cancer

☐Heart Attack

☐Hypertrophic Cardiomyopathy

☐Inflammatory bowel disease/ Crohn's disease

☐Weight problems that affect your health

☐Kidney (renal) failure

☐Liver failure

☐Mental health problems

☐Obstructive sleep apnoea

☐Other lung problems that limit you

☐Other significant mobility problems

☐Significant visual impairment

☐Other

LHCH Waiting List Survey 2020

Other Please specify:

7. On average, how often do you manage to complete at least half an hour of moderately strenuous exercise (such as a brisk walk)?

☐ Every day or more often

☐ 5-6 times per week

☐ 3-4 times per week

☐ 1-2 times per week

☐ Less than once per week

☐ Never

8. Which anticoagulant medication do you take?

☐ Dabigatran/Pradaxa

☐ Rivaroxaban/Xarelto

☐ Apixaban/Eliquis

☐ Edoxoban/Lixiana

☐ Warfarin

☐ None

9. For what length of time have you suffered from AF (since you first had symptoms)?

☐ Less than 1 year

☐ 1-2 years

☐ 2-3 years

☐ 3-4 years

☐ 4-5 years

☐ 5-6 years

☐ 6-7 years

☐ 7-8 years

☐ 8-9 years

☐ 9-10 years

☐ greater than 10 years

10. Do you have a pacemaker or defibrillator/ICD fitted?

☐ No

☐ Yes – but I don't know what kind of device

☐ Yes – a pacemaker

☐ Yes – a defibrillator / ICD

11. How concerned are you about coronavirus delaying your ablation for atrial fibrillation?

☐ - not at all ☐ - mildly ☐ - a moderate extent ☐ - very concerned

12. Have you ever been admitted to hospital as a result of atrial fibrillation?

☐ Yes ☐ No

13. If you have been admitted to hospital as a result of atrial fibrillation, how often has this happened?

☐ once ☐ 2-4 times ☐ 5 or more times

14. During the Covid-19 lockdown period have you had symptoms from your atrial fibrillation that you would previously have sought medical attention for?

☐ Yes and I attended A&E ☐ Yes and I was admitted to hospital

☐ Yes and I saw a doctor e.g GP ☐ Yes but I did not seek medical attention

☐ No

15. How concerned are you about coming to the hospital for your ablation treatment in terms of the risks of contracting coronavirus?

☐ - not at all ☐ - mildly ☐ - a moderate extent ☐ - very concerned

The next section has two specially designed forms often used in clinical trials of atrial fibrillation (AF) for you to complete. It is important you take time to try to complete all the questions on these forms. Once you have completed these please send the whole questionnaire back to us in the envelope provided. Thanks for your help.

Start the next section here:

Are you currently in atrial fibrillation? ☐ Yes ☐ No

If **No**, when was the last time you were aware of having had an episode of atrial fibrillation? (Please tick one answer which best describes your situation)

☐ earlier today ☐ 1 month to 1 year ago

☐ within the past week ☐ more than 1 year ago

☐ within the past month ☐ I was never aware of having atrial fibrillation

Over the past four weeks, as a result of your atrial fibrillation, how frequently were you bothered by:
(Please circle one number which best describes your situation)

	Not at all bothered or I did not have this symptom	Hardly bothered	A little bothered	Moderately bothered	Quite a bit bothered	Very bothered	Extremely bothered
1. Palpitations: Heart fluttering, skipping or racing	1	2	3	4	5	6	7
2. Irregular heart beat	1	2	3	4	5	6	7
3. A pause in heart activity	1	2	3	4	5	6	7
4. Light-headedness or dizziness	1	2	3	4	5	6	7

Over the past four weeks, have you been limited by your atrial fibrillation in your:
(Please circle one number which best describes your situation)

	Not at all limited	Hardly limited	A little limited	Moderately limited	Quite a bit limited	Very limited	Extremely limited
5. Ability to have recreational pastimes, sports, and hobbies	1	2	3	4	5	6	7
6. Ability to have a relationship and do things with friends and family	1	2	3	4	5	6	7

Over the past four weeks, as a result of your atrial fibrillation, how much difficulty have you had in:
(Please circle one number which best describes your situation)

	No difficulty at all	Hardly any difficulty	A little difficulty	Moderate difficulty	Quite a bit of difficulty	A lot of difficulty	Extreme difficulty
7. Doing any activity because you felt tired, fatigued, or low on energy	1	2	3	4	5	6	7
8. Doing physical activity because of shortness of breath	1	2	3	4	5	6	7
9. Exercising	1	2	3	4	5	6	7
10. Walking briskly	1	2	3	4	5	6	7
11. Walking briskly uphill or carrying groceries or other items, up a flight of stairs without stopping	1	2	3	4	5	6	7
12. Doing vigorous activities such as lifting or moving heavy furniture, running, or participating in strenuous sports like tennis or racquetball	1	2	3	4	5	6	7

Over the past four weeks as a result of your atrial fibrillation, how much did the feelings below bother you?
(Please circle one number which best describes your situation)

	Not at all bothered	Hardly bothered	A little bothered	Moderately bothered	Quite a bit bothered	Very bothered	Extremely bothered
13. Feeling worried or anxious that your atrial fibrillation can start anytime	1	2	3	4	5	6	7
14. Feeling worried that atrial fibrillation may worsen other medical conditions in the long run	1	2	3	4	5	6	7

Over the past four weeks, as a result of your atrial fibrillation treatment, how much were you bothered by:
(Please circle one number which best describes your situation)

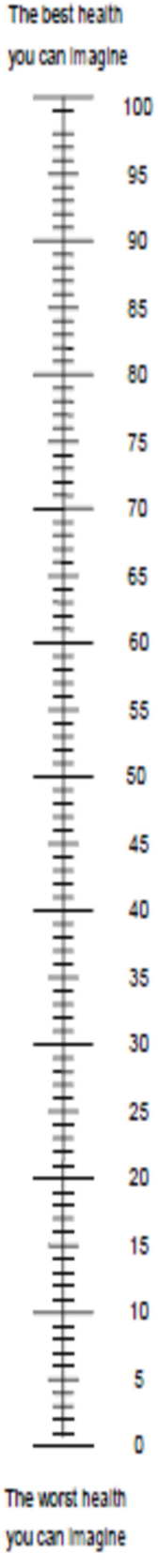
	Not at all bothered	Hardly bothered	A little bothered	Moderately bothered	Quite a bit bothered	Very bothered	Extremely bothered
15. Worrying about the treatment side effects from medications	1	2	3	4	5	6	7
16. Worrying about complications or side effects from procedures like catheter ablation, surgery, or pacemaker therapy	1	2	3	4	5	6	7
17. Worrying about side effects of blood thinners including nosebleeds, bleeding gums when brushing teeth, heavy bleeding from cuts, or bruising	1	2	3	4	5	6	7
18. Worrying or feeling anxious that your treatment interferes with your daily activities	1	2	3	4	5	6	7

Overall, how satisfied are you at the present time with:
(Please circle one number which best describes your situation)

	Extremely satisfied	Very satisfied	Somewhat satisfied	Mixed with satisfied and dissatisfied	Somewhat dissatisfied	Very dissatisfied	Extremely dissatisfied
19. How well your current treatment controls your atrial fibrillation?	1	2	3	4	5	6	7
20. Extent to which treatment has relieved your symptoms of atrial fibrillation?	1	2	3	4	5	6	7

We would like to know how good or bad your health is <u>today.</u>
The scale is numbered from 0 to 100.
100 means the <u>best</u> health you can imagine
0 means the <u>worst</u> health you can imagine
Mark an X on the scale to indicate how your health is TODAY
Now, please write the number you marked in the box here.

Your Health Today:



Under <u>each</u> heading, please tick the <u>ONE</u> box that best describes your health <u>TODAY</u>

MOBILITY
I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE
I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*
I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN / DISCOMFORT
I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION
I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐