For Trial Staff Only. CHANGE AFib Patient ID: _____

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Section 1. Occurrence of atrial fibrillation **Name or ID:_____**

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 check one answer which best describes your situation)

__earlier today
__within the past week
__within the past month
__1 month to 1 year ago
__ more than 1 year ago
__I was never aware of having atrial fibrillation

Section 2. The following questions refer to how atrial fibrillation affects your quality of life.

On a scale of 1 to 7, over the past 4 weeks, as a result of your atrial fibrillation, how much 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. Lightheadedness or dizziness	1	2	3	4	5	6	7

On a scale of 1 to 7, over the past 4 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

On a scale of 1 to 7, over the past 4 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

Developed by AFEQT Core Team-John Spertus, MD, Mid America Heart Institute, Kansas City, MO; Paul Dorian, MD, St. Michaels Hospital, Toronto, ON; Rosemary Bubien, RN, University of Alabama, Birmingham, AL; Caroline Burk, Pharm D. M.S; Steven Lewis, PhD; Donna Godejohn, BSN, St. Jude Medical, St. Paul, MN.

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On a scale of 1 to 7, over the past 4 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

On a scale of 1 to 7, over the past 4 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 pacemakers therapy	1	2	3	4	5	6	7
17. Worrying about side effects of blood thinners such as 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

On a scale of 1 to 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. The extent to which treatment has relieved your symptoms of atrial fibrillation?	1	2	3	4	5	6	7

Name or ID:_____

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