

CORONARY REVASCULARISATION OUTCOME QUESTIONNAIRE (CROQ-CABG v2)

INSTRUCTIONS: We are interested in finding out how you have been since your heart operation. 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"/>				
Discomfort in your chest due to angina	<input type="checkbox"/>				
Shortness of breath	<input type="checkbox"/>				
Angina pain that radiates to other parts of your body (eg arms, shoulders, hands, neck, throat, jaw, back)	<input type="checkbox"/>				
Palpitations (strong or irregular heart beat)	<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"/>				
A lot	Quite a bit	Some	A little	None

4. This question asks 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"/>
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"/>

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"/>

8. This question asks 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**

Infection in your **chest wound**

Tenderness around your **chest wound**

Numbness or tingling around your **chest wound**

Bruising on your **chest**

Pain in your **leg or arm wound**

Any other pain in your **leg or arm** due to your operation

Infection in your **leg or arm wound**

Numbness or tingling in your **leg or arm** due to your operation

Bruising on your **leg or arm** where a vein was removed

Swollen feet or ankles

9. This 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?

Information you were given about your heart operation?

Information you were given about how you might feel while recovering from your heart operation?

10. 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

11. 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?

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

Worse than you
expected?

About what you
expected?

Better than you
expected?