# Pulmonary Arterial Hypertension (PAH)
## Tell Us How You Are Feeling/Doing

### Where You Are Now

**1 How have you felt overall in the last few weeks?**

- ☐ Better than usual
- ☐ About the same as usual
- ☐ Worse than usual

**2 In the last few weeks, have you missed any work, school, or normal daily activities due to chest pain, fatigue, swelling, worsened shortness of breath, or other PAH-associated symptoms?**

☐ No ☐ Yes

If yes, please explain _____

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**3 If you have experienced a rapid or irregular heartbeat in the last few weeks, how would you describe them?**

- ☐ Less severe than usual
- ☐ About the same as usual
- ☐ More severe than usual
- ☐ N/A - I have not experienced any rapid or irregular heartbeats

**4 If you have experienced any dizziness in the last few weeks, how would you describe it?**

- ☐ Less severe than usual
- ☐ About the same as usual
- ☐ More severe than usual
- ☐ N/A – I have not experienced any dizziness

**5 If you have experienced any swelling in your legs, feet, and abdomen in the last few weeks, how would you describe it?**

- ☐ Less severe than usual
- ☐ About the same as usual
- ☐ More severe than usual
- ☐ N/A – I have not experienced any swelling in my legs

**6 If you have been prescribed oxygen, how would you describe your oxygen use in the last few weeks?**

- ☐ I use oxygen while sleeping at night
- ☐ I use oxygen during physical activities
- ☐ I use oxygen most of the day and night
- ☐ N/A – I have not been using oxygen

**Please see back for additional questions.**

Visit PAHInitiative.com for easy-to-understand information about PAH, a downloadable symptom tracker, and much more!

## Let's Talk Activities

**7** **In the last few weeks, have you been able to do all your activities at the same frequency as usual?**

- ☐ I have increased the frequency of one or more activities
- ☐ I am able to do all of the same activities at the same frequency
- ☐ I have cut back on the frequency of one or more activities
- ☐ I have completely stopped doing one or more activities

**8** **Rate how you feel while completing the following activities:**

| | NOT BREATHLESS AT ALL | SOMEWHAT BREATHLESS | TOO BREATHLESS TO COMPLETE |
|---|---|---|---|
| **Walking up stairs or up a hill** | ☐ | ☐ | ☐ |
| **Walking on level ground** | ☐ | ☐ | ☐ |
| **Sweeping the floor** | ☐ | ☐ | ☐ |
| **Making the bed** | ☐ | ☐ | ☐ |
| **Getting dressed** | ☐ | ☐ | ☐ |
| **Talking to someone** | ☐ | ☐ | ☐ |
| **Carrying groceries** | ☐ | ☐ | ☐ |
| **Showering** | ☐ | ☐ | ☐ |

**9** **Have any other activities caused you to experience symptoms? If yes, please explain below.**

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**10** **Please list any activities that you would like to do that you are unable to do now.**

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