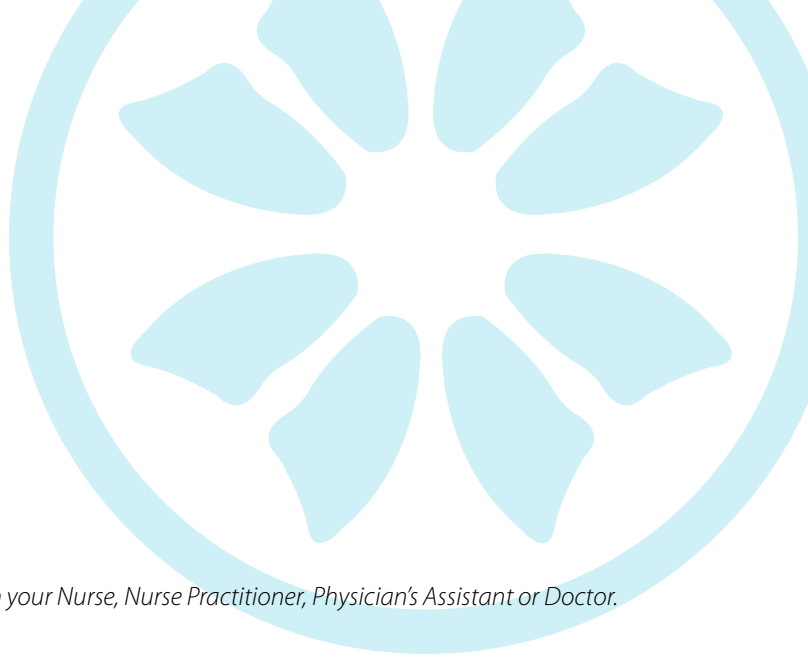




More than medicine. More to life.

PAH Self-Assessment Survey



Name: _____

Today's Date: _____

Please answer the questions below, and share the completed survey with your Nurse, Nurse Practitioner, Physician's Assistant or Doctor.

1. How do you feel overall compared with your last visit?

- Better
- Worse
- Same

Describe: _____

2. Has your activity level changed since your last visit?

- Better
- Worse
- Same

Describe: _____

3. Do you experience shortness of breath while:

- | | | |
|-----------------------------------|---------------------------|--------------------------|
| a. walking on level ground? | <input type="radio"/> Yes | <input type="radio"/> No |
| b. walking up stairs or up hills? | <input type="radio"/> Yes | <input type="radio"/> No |
| c. making the bed? | <input type="radio"/> Yes | <input type="radio"/> No |
| d. getting dressed? | <input type="radio"/> Yes | <input type="radio"/> No |
| e. sweeping the floor? | <input type="radio"/> Yes | <input type="radio"/> No |

4. Are you able to walk through the grocery store or do you use the electric cart?

- Walk
- Walk holding the grocery cart
- Use electric cart

5. Have you missed any work, school or normal daily activities due to chest pain, fatigue, swelling, worsening shortness of breath or other Pulmonary Arterial Hypertension-associated symptoms since your last visit?

- Yes
- No

6. Have you experienced any chest pain or palpitations since your last visit?

- Yes
- No
- If yes: Better Worse Same

7. Have you experienced any dizziness or fainting since your last visit?

- Yes
- No



To learn more about the Living PAH program, please visit livingpah.com



8. Have you had swelling in your legs? If so, is it better, worse or the same since your last visit?

Yes

No

If yes: Better Worse Same

9. Have you been strictly following a 2 gram sodium and 2 liter fluid restriction, if applicable?

Yes

No

N/A

10. Have you had any infections since your last visit?

Yes

No

If yes, treatment with antibiotics?

Yes

No

11. Have you had any hospitalizations since your last visit?

Yes

No

12. Have you been using your oxygen consistently, if applicable?

Yes

No

N/A

13. What Pulmonary Arterial Hypertension medications are you currently taking?

Please list: _____

14. Have you missed any doses of any of your Pulmonary Arterial Hypertension medications?

Yes

No

If yes, which medications? _____

Any particular reason? _____

15. Have you experienced any side effects from your Pulmonary Arterial Hypertension medication(s)?

Yes

No

If yes, which medications? _____

Please describe your symptoms: _____

16. Have you made any medication changes since your last visit? (Describe using space below)

Started

Stopped

_____	_____
_____	_____
_____	_____