ACS QUIK 30-Day Follow-Up Form v1.0

Patient Information

~~Last Name:~~ ~~First Name:~~ ~~Middle Name:~~

~~ACS QUIK ID:~~ ~~Other ID:~~

A. First Contact Attempt

1 Contacted Patient
2 Other → First Name: ____________ Last Name: ____________
F1ContactedPerson

Date (DD/MMM/YYYY): ____________ DischargeToFirstContact ☐AM ☐PM

Time (HH:MM): ____________

1 Telephone
2 Office Visit
F1ModeOfContact

1 Completed Follow-Up
2 Contact Again
F1ContactFupStatus

Relationship of contact to the patient: F1ContactRelationShip
1 Relative 2 Care Provider 3 Other: ____________ F1ContactRelationShipOther

B. Second Contact Attempt (if First Contact Attempt was Unsuccessful or "Contact Again")

1 Contacted Patient
2 Other → First Name: ____________ Last Name: ____________
F2ContactedPerson

Date (DD/MMM/YYYY): ____________ DischargeToSecondContact ☐AM ☐PM

Time (HH:MM): ____________

1 Telephone
2 Office Visit
F2ModeOfContact

1 Completed Follow-Up
2 Contact Again
F2ContactFupStatus

Relationship of contact to the patient: F2ContactRelationShip
1 Relative 2 Care Provider 3 Other: ____________ F2ContactRelationShipOther

C. Third Contact Attempt (if First and Second Contact Attempts were Unsuccessful or "Contact Again")

1 Contacted Patient
2 Other → First Name: ____________ Last Name: ____________
F3ContactedPerson

Date (DD/MMM/YYYY): ____________ DischargeToThirdContact ☐AM ☐PM

Time (HH:MM): ____________

1 Telephone
2 Office Visit
F3ModeOfContact

1 Completed Follow-Up
4 Follow-Up Unsuccessful
F3ContactFupStatus

Relationship of contact to the patient: F3ContactRelationShip
1 Relative 2 Care Provider 3 Other: ____________ F3ContactRelationShipOther

D. Follow-Up Measures

Patient Status FUpPatientStatus

☐1 Deceased → FUpDeceased Day30Death

Underlying cause of death:

- ☐1 Ischemic heart disease
- ☐2 Other, cardiovascular cause of death (not ischemic heart disease)
- ☐3 Non-cardiovascular death

☐2 Alive → FUpAlive

- ☐1 No major adverse cardiovascular event
- ☐2 Major adverse cardiovascular event, restricted to:
  - ☐ Stroke Day30Stroke
  - ☐ Recurrent MI Day30Reinfarction
  - ☐ Major bleeding by GUSTO criteria defined as one of the following: Day30MajorBleeding
    - ~~☐ Severe (Either intracranial hemorrhage or bleeding that causes hemodynamic compromise and requires intervention)~~
    - ~~☐ Life Threatening (Either intracranial hemorrhage or bleeding that causes hemodynamic compromise and requires intervention)~~
- ☐3 Other: FUpAliveOther ______________

☐3 Missing → Number of attempts to contact: FupNoOfAttemptsContact ______________

E. Additional Follow-Up

~~Patient requested to complete Seattle Angina Questionnaire~~			~~Patient requested to complete Micro-Economic Assessment~~		
~~☐ Yes~~ ~~☐ No~~	→ ~~If Yes, was questionnaire completed?~~	~~☐ Yes~~ ~~☐ No~~	~~☐ Yes~~ ~~☐ No~~	→ ~~If Yes, was questionnaire completed?~~	~~☐ Yes~~ ~~☐ No~~

ACS QUIK Case Report Form v1.0

A. Demographics

~~Last Name:~~ | ~~First Name:~~ | ~~Middle Name:~~

Birth Date (DD/MMM/YYYY): Age

Sex: 1 Male 0 Female Male

~~Hospital Patient ID:~~ | ~~Other ID:~~ | ~~Postal Code of Patients Primary Address:~~

B. Admission

Means of Transport to First Facility: MeansTransport

1 Self/Family
2 Public Transport
3 Taxi
4 Ambulance →

If Ambulance, Pre-Arrival 1st Medical Contact Date/Time: AmbulanceEstimated

Date (DD/MMM/YYYY): AmbulanceToArrival ________ 1 Estimated

Time (HH:MM): ________ ☐AM ☐PM

Transferred from Outside Facility: TransferPatient

1 Yes → If Yes, Means of Transfer: 4 Ambulance 1 Self/Family 2 Public Transport 3 Taxi TransferMeans

2 No

~~If Yes, Name of Transferring Facility:~~ ________

If Yes, Arrival at Outside Facility Date/Time

Date (DD/MMM/YYYY): OtherFacilityToArrival ________ OtherFacilityEstimated

Time (HH:MM): ________ ☐AM ☐PM 1 Estimated

If Yes, Transfer from Outside Facility Date/Time

Date (DD/MMM/YYYY): TransferToArrival ________ TransferEstimated

Time (HH:MM): ________ ☐AM ☐PM 1 Estimated

At your Facility:

ArrivalEstimated

Arrival Date (DD/MMM/YYYY): ________ Time (HH:MM): ________ ☐AM ☐PM 1 Estimated

AdmissionEstimated

Admission Date (DD/MMM /YYYY): ArrivalToAdmission ________ Time (HH:MM): ________ ☐AM ☐PM 1 Estimated

Health Insurance (check all that apply): PrivateInsurance PublicInsurance MilitaryInsurance NoInsurance OtherInsurance

☐Private Health Insurance ☐Public Health Insurance ☐Military Health Insurance ☐None ☐Other: ________

Chief Complaint on Presentation: ChiefComplaint

1 Chest Pain
2 Shortness of Breath
3 Cardiac Arrest
4 Dizziness/Weakness
5 Syncope
6 Abdominal Pain
7 Other: OtherComplaint ________

C. Cardiac Status on First Medical Contact

Symptom Onset

Date (DD/MMM/YYYY): OnsetToArrival ________ OnsetTimeEstimated 1 Estimated OnsetTimeNotAvailable 1 Time not Available

Time (HH:MM): ________ ☐AM ☐PM

First ECG

Date (DD/MMM/YYYY): ArrivalToECG ________ FirstECGEstimated 1 Estimated

Time (HH:MM): ________ ☐AM ☐PM

First ECG Obtained:
1 Pre-Hospital
2 After Hospital Arrival
FirstECGTiming

STEMI or STEMI Equivalent: (STEMI Equivalent is new or presumed new left bundle branch block in setting of chest pain) CardiacStatusSTEMI

[1] Yes → If Yes, ECG Findings: ☐ST Elevation STElevation ☐LBBB (new or presumed new) LBBB ☐Isolated Posterior MI IsolatedPosteriorMI

If Yes, First Noted: [1] First ECG STEMINoted [2] Subsequent ECG → Date (DD/MMM/YYYY): ArrivalToSecondECG ________ [1] Estimated SubsequentECGEstimated

Time (HH:MM): ____________ ☐AM ☐PM

[0] No → If No, Other ECG Findings: ☐New or presumed new ST Depression STDepression ☐New or presumed new T-Wave inversion TWaveInversion

TransientSTElevation ☐Transient ST Elevation lasting <20 min ☐None NoECGFindings

Heart Failure:	Cardiogenic Shock:	Presenting Heart Rate:	Presenting Systolic BP:	Cardiac Arrest: CardiacArrest			
[1] Yes	[1] Yes CardiogenicShock			[1] Yes →	If Yes, Pre-Hospital? CardiacArrestPreHospital	[1] Yes	[0] No
[0] No HeartFailure	[0] No	HeartRate ____ BPM	SBP ____ mmHg	[0] No	If Yes, Outside Facility? CardiacArrestOutside	[1] Yes	[0] No

Killip Class KillipClass

[1] I (no clinical signs of heart failure)

[2] II (rales or crackles in the lungs, an S3 gallop, or elevated jugular venous pressure)

[3] III (pulmonary edema)

[4] IV (cardiogenic shock or hypotension, and evidence of peripheral vasoconstriction)

D. History and Risk Factors

Weight: Weight ________ kg				Diabetes Mellitus:	[1] Yes	[0] No	Diabetes
				Hypertension:	[1] Yes	[0] No	Hypertension
Current/Recent Smoke (<1 year): Smoking	[1] Yes	[0] No		Cerebrovascular Disease: (prior transient ischemic attack (TIA) or stroke)	[1] Yes	[0] No	Cerebrovascular
Chewing tobacco (<1 year): ChewingTobacco	[1] Yes	[0] No		→ If Yes, Prior Stroke:	[1] Yes	[0] No	Stroke
Currently on Dialysis: Dialysis	[1] Yes	[0] No		Peripheral Arterial Disease:	[1] Yes	[0] No	PAD

E. Medications

Oral Medications

Pre Hospital Medications:

Aspirin PreHospitalAspirin	[1] Contraindicated [0] No [2] Yes	Lytics PreHospitallytics	[1] Contraindicated [0] No ☐Yes	Antiplatelet PreHospitalAntiplatelet	[1] Contraindicated [0] No ☐Yes

Medication	**Medications Administered in First 24 Hours** (up to 24 hours after first medical contact)		**Medications Prescribed at Hospital Discharge** (not required for deceased patients or patients discharged to Other Hospital, Hospice, or 'AMA')	
Aspirin InHospitalAspirin	[1] Contraindicated [0] No [2] Yes →	Start Date (DD/MMM/YYYY): ArrivalToAspirin Start Time (HH:MM): ________	[1] Contraindicated [2] Yes [0] No	PrescribedAspirin
Clopidogrel InHospitalClopidogrel	[1] Contraindicated [0] No [2] Yes →	ArrivalToClopidogrel Start Date (DD/MMM/YYYY): ________ Start Time (HH:MM): ________ Dose: ClopidogrelDose mg	[1] Contraindicated [2] Yes [0] No	PrescribedClopidogrel
Prasugrel InHospitalPrasugrel	[1] Contraindicated [0] No [2] Yes →	ArrivalToPrasugrel Start Date (DD/MMM/YYYY): ________ Start Time (HH:MM): ________	[1] Contraindicated [2] Yes [0] No	PrescribedPrasugrel
Ticagrelor InHospitalTicagrelor	[1] Contraindicated [0] No [2] Yes →	ArrivalToTicagrelor Start Date (DD/MMM/YYYY): ________ Start Time (HH:MM): ________	[1] Contraindicated [2] Yes [0] No	PrescribedTicagrelor
Beta Blocker InHospitalBetaBlocker	[1] Contraindicated [0] No [2] Yes		[1] Contraindicated [2] Yes [0] No	PrescribedBetaBlocker

Warfarin		[1] Contraindicated PrescribedWarfarin [2] Yes [0] No
ACE Inhibitor		[1] Contraindicated PrescribedACEI [2] Yes [0] No
Angiotensin Receptor Blocker		[1] Contraindicated PrescribedARB [2] Yes [0] No
Aldosterone Blocking Agent		[1] Contraindicated PrescribedAldosterone [2] Yes [0] No
Statin		[1] Contraindicated PrescribedStatin [2] Yes [0] No

Intravenous and Subcutaneous Medications GlycoproteinInhibitorType

GP IIb/IIIa Inhibitor (any time)	[1] Contraindicated [0] No GlycoproteinInhibitor [2] Yes →	Medication Type: [1] Eptifibatide [2] Tirofiban [3] Abciximab Date (DD/MMM/YYYY): ArrivalToGPIIbMed ________ Time (HH:MM): ________
Anticoagulant Anticoagulant	[1] Contraindicated [0] No [2] Yes →	Medication Type: [1] IV Unfractionated Heparin [2] Enoxaparin (LMWH) [3] Dalteparin (LMWH) [4] Bivalirudin [5] Fondaparinux [6] Argatroban [7] Lepirudin AnticoagulantType

F. Procedures and Tests

Mode of assessment

Echocardiography: [1] Yes [0] No Echo

Diagnostic Coronary Angiography: [1] Yes [0] No Angiography

LVEF: [1] <=40% [2] 40-70%: LVEF ____ [3] >=70% [4] Unknown or Not Assessed LVEFCategory

PCI: [0] No (move to CABG) [1] Yes (complete all following) PCI

Cath Lab Arrival Date/Time:	Date (DD/MMM/YYYY): Time (HH:MM):	ArrivalToCath ________ ________	[1] Estimated CathArrivalEstimated ☐ AM ☐ PM
First Device Activation Date/Time:	Date (DD/MMM/YYYY): Time (HH:MM):	ArrivalToDevice ________ ________	[1] Estimated FirstDeviceEstimated ☐ AM ☐ PM

Stent(s) Placed: [0] No [1] Yes (complete following) StentsPlaced

Stent(s) Placed Location	Type of Stent(s) Placed (Number placed):			Brand Name(s):
☐ Left main coronary artery	☐ BMS: N_BMS	☐ DES: N_DES	☐ Other: N_Other	Brand ________
☐ Left anterior descending artery	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________
☐ Left circumflex artery	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________
☐ Right coronary artery	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________
☐ Posterior descending artery	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________
☐ Ramus intermedius artery	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________
☐ Diagonal artery	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________
☐ Obtuse marginal artery	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________
☐ Other (culprit lesion): Location ________	☐ BMS: ____	☐ DES: ____	☐ Other: ____	________

PCI Indication: PCIIndication

[1] Immediate, primary PCI for STEMI →

[2] Rescue PCI (after failed full-dose lytics for STEMI)

[3] PCI for NSTEMI

[4] Stable, successful reperfusion for STEMI, or completed infarction post-STEMI

[5] Other

PCIDelay If Immediate, primary PCI for STEMI, the Non-System Reason for Delay in PCI: PCIDelayAccess PCIDelayPatientConsent

☐ Difficult Vascular Access ☐ Patient delays in providing consent

☐ Cardiac arrest and/or need for intubation before PCI PCIDelayCardiacArrest

☐ Difficulty crossing the culprit lesion during the PCI Procedure PCIDelayCrossingLesion

☐ Other PCIDelayOther

☐ None PCIDelayNone

CABG: 0 No 1 Yes CABG ArrivalToCABG CABGEstimated

G. Reperfusion Strategy (Immediate Reperfusion) if STEMI or STEMI Equivalent = Yes

Was Patient a Reperfusion Candidate ReperfusionCandidate ThrombolyticsTimeEstimated

1 Yes → If Yes (choose one), PrimaryPCI Date (DD/MMM/YYYY): ArrivalToLytics ________ 1 Estimated
0 No Primary PCI: 0 No 1 Yes Dose ☐AM ☐PM
Thrombolytics Thrombolytics: 0 No 1 Yes → Start: Time (HH:MM): ________

Was Rescue or Facilitated PCI performed?
0 No 1 Rescue 2 Facilitated PCIType

Was there any Non-System reason for Delay for any reperfusion care?
0 No 1 Yes: ReperfusionDelay ________

H. In-Hospital Clinical Events

Reinfarction: InHospitalReinfarction 0 No 1 Yes
RBC/Whole Blood Transfusion: InHospitalBloodTransfusion 0 No 1 Yes
CVA/Stroke: InHospitalCVAStroke 0 No 1 Yes
Cardiogenic Shock: InHospitalCardiogenicShock 0 No 1 Yes
Heart Failure: InHospitalHeartFailure 0 No 1 Yes
Cardiac Arrest: InHospitalCardiacArres 0 No 1 Yes
→ If Yes, Hemorrhagic: InHospitalHemorrhagic 0 No 1 Yes
→ If Yes, Date: ArrivalToHemorrhage

Major Bleeding by GUSTO Criteria: InHospitalGUSTOCriteria
1 Severe (Either intracranial hemorrhage or bleeding that causes hemodynamic compromise and requires intervention)
2 Life-Threatening (Either intracranial hemorrhage or bleeding that causes hemodynamic compromise and requires intervention)
3 Moderate (Bleeding that requires blood transfusion but does not result in hemodynamic compromise)
4 Mild (Bleeding that does not meet criteria for either severe or moderate bleeding)

I. Laboratory Results

Positive Cardiac Markers within First 24 Hours: 0 No 1 Yes PositiveMarkers

Troponin TroponinCollected
Initial Collected: If yes, (quantitative or qualitative)
1 Yes → Value: Troponin (ng/mL) or 1 + 2 - TroponinSign
0 No ULN: TroponinULN

Creatinine Kinase (CK-MB) LabCKMBCollected
Initial Collected: If yes,
1 Yes → Value: LabCKMB ________ (units/L)
0 No

Hemoglobin LabHBCollected
Initial Collected: If yes,
1 Yes → Value: LabHB ________ (g/dL)
0 No

Creatine Phosphokinase (CPK) LabCreatineCollected
Initial Collected: If yes, LabCreatinine
1 Yes → Value: LabCPK ________ (units/L)
0 No

Lipids: LabLipidsCollected
Initial Collected: If yes,
1 Yes → HDL: LabHDL ________ (mg/dl)
0 No LDL: LabLDL ________ (mg/dl)
Triglycerides: LabTrig ________ (mg/dl)

Fasting Blood Glucose: LabFGCollected
Initial Collected: If yes, LabFG
1 Yes → Value: ________ (mg/dl)
0 No

Non-fasting/Random Blood Glucose: LabNonFGCollected
Initial Collected: If yes, LabNonFG
1 Yes → Value: ________ (mg/dl)
0 No

J. Discharge

Discharge Date/Time Date (DD/MMM/YYYY): ArrivalToDischarge ________ 1 Estimated DischargeEstimated
DischargeStatus Time (HH:MM): ________ ☐AM ☐PM

Comfort Measures Only:
1 Yes ComfortMeasuresOnly
0 No

Discharge Status:
1 Deceased
2 Alive → If Alive:

SmokingCounseling
Smoking Counseling: 1 Yes 0 No

ExerciseCounseling
Exercise Counseling: 1 Yes 0 No 3 Ineligible

CardiacRehab
Cardiac Rehabilitation Referral: 1 Yes 0 No 3 Ineligible

Discharge Location: DischargeLocation
1 Home 2 Extended care/transitional care unit 3 Nursing Home 4 Hospice 5 Other 6 Left against medical advice (AMA)
7 Other Hospital → If Other Hospital, Transfer Time (HH:MM): ________ ☐AM ☐PM Transfer for PCI: 1 Yes 0 No TransferForPCI

K. Scheduled Follow Up (Optional Elements)

Follow up (scheduled) Date/Time ~~Date (DD/MMM/YYYY):~~ ________ ☐AM ☐PM ~~☐Telephone (number):~~ ________
~~Time (HH:MM):~~ ________ ~~☐Office Visit~~

ACS QUIK Micro-Economic Assessment v1.0

NORTHWESTERN UNIVERSITY

CENTRE FOR CHRONIC DISEASE CONTROL

A. Patient & Interview Information

~~Last Name:~~ ~~First Name:~~ ~~Middle Name:~~

~~Birth Date (DD/MM/YYYY):~~ ~~Sex: ☐Male ☐Female~~

~~Hospital Patient ID:~~ ACS QUIK ID:

Hospital Code: ~~Interviewer Name (Paper Form):~~

~~Interviewer will also abstract data to the EDC? ☐Yes ☐No →~~ ~~If No, who will abstract the data:~~

~~Interview Date (DD/MM/YYYY):~~ FollowUpTime ______________

Interview Location: IdenLocOfInterview
1 Hospital 2 Home 3 Telephone 4 Other: ______________

Is the Patient the respondent? IdenPatientRespondent 1 Yes 0 No → If No, what is the relationship of the respondent to the patient? IdenRelationWithPatient ______________
~~If No, what is the respondent's name (First, Last) :~~ ______________

B. Patient Background

Can the patient? PBackAbleToReadOrWrite
1 Read
2 Write (3 = Read and Write)
4 Illiterate

What is the patient's education level? PBackHigestSchooling
1 Never attended school 2 Primary school 3 Secondary School 4 High School
5 College / University 6 Professional Degree 7 Other: PBackHigestSchoolingOther ______________

Years of education completed: PBackYearsOfEducation ________

Marital Status: PBackMaritalStatus
1 Never married 2 Divorced 3 Widow/Widower 4 Currently Married 5 Living with Partner

Main Occupation: PBackCurrentOccupation
1 Unemployed 3 Student 5 Worker
4 Government Employee 9 Professional 7 Farmer
6 Enterprise Employee 8 Service Attendant 2 Retired
10 Other PBackCurrentOccupationOther ________

If Retired, what was the patient's previous occupation? PBackPreviousOccupationOfRetired
1 Unemployed 2 Student 5 Worker
4 Government Employee 9 Professional 7 Farmer
6 Enterprise Employee 8 Service Attendant
10 Other ______________

What health problems does the patient currently have?
☐None NoHealthIssues ☐Heart Related HeartIssues ☐Stroke StrokeIssues ☐Diabetes DiabetesIssues ☐Hypertension HypertensionIssues ☐Depression DepressionIssues
☐Chronic obstructive lung disease/emphysema/asthma COPDLungIssues ☐Other: OtherHealthIssues ________ PBackHealthProblemsOther

When was the patient first diagnosed with a heart or stroke problem? Year (YYYY): YearDiagnosed Month (MM): MonthDiagnosed

C. Hospitalizations

In the past 15 months, how many times was the patient hospitalized for heart related disease or stroke? CVDNoOfTimesHospitalised

CA. Hospitalization 1

When were you hospitalized? Year (YYYY): YearDiagnosed Month (MM): MonthDiagnosed

How many days were you in the hospital? Days: DaysHospitalized

What type of hospital were you in? HospitalType 1 Government 2 Private 3 Charity 4 Other OtherType

What specific problem were you diagnosed with?
☐Acute Coronary Syndrome ACS ☐Stroke Stroke ☐Acute Heart Failure HeartFailure ☐Peripheral Vascular Disease PVD ☐Other: OtherHeartProblem OtherHeartProblemType

Did you undergo any interventional treatment related to heart disease or stroke?
1 Yes → InterventionTreatment
0 No

What type of treatment/Procedure/Surgery did you undergo?
☐Medicines Medicines ☐Thrombolysis Thrombolysis ☐Angiogram Angiogram ☐Angioplasty Angioplasty
☐Bypass Surgery Bypass ☐Brachytherapy Brachytherapy ☐Pacemaker Pacemaker ☐Heart Transplant Transplant
☐Amputation Amputation ☐Echocardiography Echocardiography ☐Neuroimaging Neuroimaging ☐Other: OtherTreatmentType OtherProcedure

For all the following, indicate the expenses incurred by the patient. Check 0 if nothing was spent by the patient. Check DK if the patient does not know or cannot remember.

Hospital Admission: HospitalAdmissionCost ☐0 ☐Don't Know Tests: TestsCost ☐0 ☐Don't Know

Emergency Room: EmergencyRoomCost ☐0 ☐Don't Know Food: FoodCost ☐0 ☐Don't Know

Treatment: TreatmentCost	☐0 ☐Don't Know	Ambulance: AmbulanceCost	☐0 ☐Don't Know
Surgery: SurgeryCost	☐0 ☐Don't Know	Other (OtherInHospital): OthersCost	☐0 ☐Don't Know
Medicines: MedicinesCost	☐0 ☐Don't Know	Total: TreatmentTotalAmtCost	☐0 ☐Don't Know

Number of days an attendant stayed with you in the hospital: AttendantDays — Total cost of attendants stay: AttendantCost

Time taken to reach the hospital (~~HH:~~MM): TimeToHospital — Distance from home to hospital (km): DistanceToHospital

Cost of travel from home to hospital (excluding ambulance): TravelCost — Cost reimbursed from health insurance: ReimbursedCost

After Hospital Discharge

Number of times per month the patient visited a health facility/doctor after hospitalization: DoctorVisits — Was the patient accompanied by a family member/attendant at the visits? ☐Yes ☐No VisitAccompanied

For all the following, indicate the expenses incurred by the patient after they were discharged from the hospital. Check 0 if nothing was spent by the patient. Check DK if the patient does not know or cannot remember.

Doctor Fees: DoctorExpense	☐0 ☐Don't Know	Physical or Occupational Rehabilitation: RehabilitationExpense	☐0 ☐Don't Know
Home/Nurse Care: HomeCareExpense	☐0 ☐Don't Know	Other (OthersDischarge): OthersExpense	☐0 ☐Don't Know
Tests: TestsExpense	☐0 ☐Don't Know	Food: FoodExpense	☐0 ☐Don't Know
Medicines: MedicinesExpense	☐0 ☐Don't Know	Total: TotalExpense	☐0 ☐Don't Know

Cost reimbursed from health insurance: ReimbursedExpense — Time taking to reach the doctor (HH:MM): TimeToDoctor — Cost of travel from home to doctor: TransportExpense

CB. Hospitalization 2 – Completed if C01 is greater than 1 These variables have the same names and labels as Hospitalization 1

When were you hospitalized? Year (YYYY):__________ Month (MM):__________ — How many days were you in the hospital? Days: ________

What type of hospital were you in? ☐Government ☐Private ☐Charity ☐Other

What specific problem were you diagnosed with?
☐Acute Coronary Syndrome ☐Stroke ☐Acute Heart Failure ☐Peripheral Vascular Disease ☐Other: ________________

Did you undergo any interventional treatment related to heart disease or stroke?
☐Yes →
☐No

What type of treatment/Procedure/Surgery did you undergo?

☐Medicines	☐Thrombolysis	☐Angiogram	☐Angioplasty
☐Bypass Surgery	☐Brachytherapy	☐Pacemaker	☐Heart Transplant
☐Amputation	☐Echocardiography	☐Neuroimaging	☐Other: ______________

For all the following, indicate the expenses incurred by the patient. Check 0 if nothing was spent by the patient. Check DK if the patient does not know or cannot remember.

Hospital Admission: __________	☐0 ☐Don't Know	Tests:__________	☐0 ☐Don't Know
Emergency Room:__________	☐0 ☐Don't Know	Food:__________	☐0 ☐Don't Know
Treatment:__________	☐0 ☐Don't Know	Ambulance:__________	☐0 ☐Don't Know
Surgery: __________	☐0 ☐Don't Know	Other (_____):__________	☐0 ☐Don't Know
Medicines: __________	☐0 ☐Don't Know	Total:__________	☐0 ☐Don't Know

Number of days an attendant stayed with you in the hospital: _________ — Total cost of attendants stay:____________

Time taken to reach the hospital (HH:MM): _____________ — Distance from home to hospital (km): _________

Cost of travel from home to hospital (excluding ambulance): __________ — Cost reimbursed from health insurance: _______

After Hospital Discharge

Number of times per month the patient visited a health facility/doctor after hospitalization: ______ — Was the patient accompanied by a family member/attendant at the visits? ☐Yes ☐No

For all the following, indicate the expenses incurred by the patient after they were discharged from the hospital. Check 0 if nothing was spent by the patient. Check DK if the patient does not know or cannot remember.

Doctor Fees: __________	☐0 ☐Don't Know	Physical or Occupational Rehabilitation: __________	☐0 ☐Don't Know
Home/Nurse Care: __________	☐0 ☐Don't Know	Other (_____): __________	☐0 ☐Don't Know
Tests: __________	☐0 ☐Don't Know	Food: __________	☐0 ☐Don't Know
Medicines: __________	☐0 ☐Don't Know	Total: __________	☐0 ☐Don't Know

Cost reimbursed from health insurance: ________	Time taking to reach the doctor (HH:MM): ______	Cost of travel from home to doctor: ___________

CC. Hospitalization 3 – Completed if C01 is greater than 2

These variables have the same names and labels as Hospitalization 1

When were you hospitalized? Year (YYYY):__________ Month (MM):__________ How many days were you in the hospital? Days: ________

What type of hospital were you in? ☐Government ☐Private ☐Charity ☐Other

What specific problem were you diagnosed with?
☐Acute Coronary Syndrome ☐Stroke ☐Acute Heart Failure ☐Peripheral Vascular Disease ☐Other: ___________________

Did you undergo any interventional treatment related to heart disease or stroke?
☐Yes →
☐No

What type of treatment/Procedure/Surgery did you undergo?
☐Medicines ☐Thrombolysis ☐Angiogram ☐Angioplasty
☐Bypass Surgery ☐Brachytherapy ☐Pacemaker ☐Heart Transplant
☐Amputation ☐Echocardiography ☐Neuroimaging ☐Other: _________________

For all the following, indicate the expenses incurred by the patient. Check 0 if nothing was spent by the patient. Check DK if the patient does not know or cannot remember.

Hospital Admission: ___________	☐0	☐Don't Know	Tests:___________	☐0	☐Don't Know
Emergency Room:___________	☐0	☐Don't Know	Food:___________	☐0	☐Don't Know
Treatment:___________	☐0	☐Don't Know	Ambulance:___________	☐0	☐Don't Know
Surgery: ___________	☐0	☐Don't Know	Other (_____):___________	☐0	☐Don't Know
Medicines: ___________	☐0	☐Don't Know	Total:___________	☐0	☐Don't Know

Number of days an attendant stayed with you in the hospital: __________ Total cost of attendants stay:______________

Time taken to reach the hospital (HH:MM): ______________ Distance from home to hospital (km): __________

Cost of travel from home to hospital (excluding ambulance): ___________ Cost reimbursed from health insurance: ________

After Hospital Discharge

Number of times per month the patient visited a health facility/doctor after hospitalization: ______ Was the patient accompanied by a family member/attendant at the visits? ☐Yes ☐No

For all the following, indicate the expenses incurred by the patient after they were discharged from the hospital. Check 0 if nothing was spent by the patient. Check DK if the patient does not know or cannot remember.

Doctor Fees: ___________	☐0	☐Don't Know	Physical or Occupational Rehabilitation: ___________	☐0	☐Don't Know
Home/Nurse Care: ___________	☐0	☐Don't Know	Other (_____): ___________	☐0	☐Don't Know
Tests: ___________	☐0	☐Don't Know	Food: ___________	☐0	☐Don't Know
Medicines: ___________	☐0	☐Don't Know	Total: ___________	☐0	☐Don't Know

Cost reimbursed from health insurance: ________	Time taking to reach the doctor (HH:MM): ______	Cost of travel from home to doctor: ___________

F. Medications

Medication Name:	Tablets per Day	Tablets per Box	Price per Box
1. Medication	TabletsPerDay	TabletsPerBox	PricePerBox
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Treatment

Have you been able to take all of the medicines prescribed for your treatment? TakeAllMeds	1 Yes, all 2 Yes, some → 3 No →	Reasons for not taking all prescribed medications: MedReason 1 Do not want to take medicine 2 Forgot to take medicines 3 No one to help 4 Medicine not available 5 Medicines too expensive 7 Side Effect 6 Other: OtherMedReason
Have you been able to see a doctor physiotherapist whenever necessary in the past 15 months? SeeDoctor	1 Yes 0 No →	Reasons for not being able to see a care professional: DoctorReason 1 Doctor/physiotherapist not available 2 Doctor/physiotherapist too far 3 Doctor/physiotherapist too expensive 5 Spare money as possible 6 Complicated procedure for care seeking 4 Other: OtherDoctorReason

How did you pay for the treatment of your heart/stroke problem (all costs including hospitalization)?

- ☐ Own Savings (%): Self
- ☐ Family members paid (%): Family
- ☐ Employer paid (%): Employer
- ☐ Borrowed from friends, relatives, employer (%): FriendsRelatives
- ☐ Borrowed from bank (%): Bank
- ☐ Sold house, land, or other assets (%): SoldAsset
- ☐ Health insurance (%): Insurance
- ☐ Other: SourceOfPayment (%): OtherSource

G. Functionality and Productivity

Would you say your current health is? CurrentHealth

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

Before you had your heart/stroke problem, how would you rate your health? PriorHealth

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

The following questions compare the patient's current health to their health before they had heart problems or stroke.

Performing moderate activities such as moving a table, pulling a chair ModerateActivities

1 Much better than before 2 Somewhat better than before 3 About the same
4 Somewhat worse than before 5 Much worse than before

Performing vigorous activities like running, lifting heavy things, playing sports VigorousActivities

1 Much better than before 2 Somewhat better than before 3 About the same
4 Somewhat worse than before 5 Much worse than before

Performing activities like climbing several flights of stairs ClimbingStairs

1 Much better than before 2 Somewhat better than before 3 About the same
4 Somewhat worse than before 5 Much worse than before

After your heart/stroke problem, did you cut down on time spent on work activities? ReducedWork

0 Yes, cut down a lot 1 Yes, cut down a little 2 No

After your heart/stroke problem, did you limit the kinds of work activities you did? LimitedWork

0 Yes, limited a lot 1 Yes, limited a little 2 No

After your heart/stroke problem, did you have difficulty performing work activities? DifficultyWork

0 Yes, a lot of difficulty 1 Yes, a little difficulty 2 No

Do you currently feel limited in the kind of work or other regular activities you do as a result of your physical health?

0 Yes, limited a lot 1 Yes, limited a little 2 No LimitedActivities

Do you feel that you are able to accomplish less than you would like to as a result of any emotional problems, such as feeling depressed or anxious? 1 Yes 0 No EmotionalInterference

Has your income changed because of your heart/stroke problem?

1 No, income is same 2 Yes, income is higher 3 Yes, income is lower PersonalIncomeChange

How much were you earning per month before you first had your heart/stroke problem? ________ PersonalIncomeBefore

How much are you currently earning per month? ________ PersonalIncomeCurrent

Has your household income changed because of your heart/stroke problem? HouseholdIncomeChange
1 No, income is same 2 Yes, income is higher 3 Yes, income is lower

What was the monthly income of your household before you first had your heart/stroke problem? ________ HouseholdIncomeBefore

What is the current monthly income of your household? ________ HouseholdIncomeCurrent

Have you had to change your job because of your heart/stroke condition? 1 Yes 0 No JobChange

Did you use tobacco in any form before you had a heart/stroke problem? 1 Yes 0 No TobaccoUseBefore

Do you currently use tobacco in any form? 1 Yes 0 No TobaccoUseCurrent

Have any members of your household stopped using tobacco in any form after you had your heart/stroke problem?
1 Yes 0 No 3 Household members never used tobacco HouseholdTobacco

What was your monthly household expenditure on tobacco prior to your heart/stroke problem? ________ TobaccoExpenseBefore

What is your current monthly household expenditure on tobacco? ________ TobaccoExpenseCurrent

Which member(s) of your family started a new job or worked more days/hours in their existing job due to your illness?
☐Parents ParentsStartedWork ☐Spouse SpouseStartedWork ☐Children ChildrenStartedWork ☐Other OtherStartedWork ☐None NoneStartedWork

Who in your family stopped working or worked less hours in their jobs because of your illness?
~~☐Parents~~ ☐Spouse SpouseStoppedWork ☐Children ChildrenStoppedWork ☐Other OtherStoppedWork ☐None NoneStoppedWork

Who in your family stopped attending school/college/university because of your illness?
~~☐Parents~~ ~~☐Spouse~~ ☐Children ChildrenStoppedSchool ☐Other OtherStoppedSchool ☐None NoneStoppedSchool

How much did you spend on health care per year before your heart/stroke problem? ________ HealthcareExpenseBefore

H. Household Characteristics

Section H focuses on the perspective of the patient on the functionality and productivity of his life after the CVD related hospitalization episode. Almost all the questions in this section are given along with their anticipated responses

How is the patient related to the head of household? RelationToHOH
1 Patient is household head
2 Spouse of household head →
3 Son/Daughter of household head →
4 Father/Mother of household head →
5 Other: ________ OtherRelationToHOH →

What is the current occupation of the head of household? HOHCurrentOccupation
1 Unemployed 3 Student 5 Worker
4 Government Employee 9 Professional 7 Farmer
6 Enterprise Employee 8 Service Attendant 2 Retired
10 Other ________ HOHOtherCurrentOccupation

If Retired, what was the head of household's previous occupation? HOHPreviousOccupation
1 Unemployed 3 Student 5 Worker
4 Government Employee 9 Professional 7 Farmer
6 Enterprise Employee 8 Service Attendant
10 Other ________ HOHOtherPreviousOccupation

Do you line in an urban or rural area? UrbanRural
1 Urban 2 Rural 3 Town

How many people in your household are below 18 years of age? ________ NumBelow18

How many people in your household are above 60 years of age? ________ NumAbove60

How many people in your household including yourself are currently earning an income? ________ NumCurrentEarners

What is the highest educational qualification among members of your household? HighestEducation
1 Never attended school 2 Primary school 3 Secondary School 4 High School
5 College / University 6 Professional Degree 7 Other: ________ HighestEducationOther

Household Expenditures

The following questions ask about household spending on various indicated items **over the past 30 days**. Please write in the amount estimated by the respondent **in the local currency.** If the respondent does not know, please write 'DK'.

Food including such things as rice, meat, fruits, vegetables, and cooking oils
Per day: ________ FoodPerDay
Per Month: ________ FoodPerMonth

Housing rent. If house is not rented, ask about the rental value of the patient's house.
Per Month: ________ RentPerMonth

Gas, electricity, water, telephone Per Month: GasPerMonth ________	Education fees and supplies Per Semester: EducationPerSemester ________
Transport Per Month: TransportPerMonth ________	Insurance premiums or prepaid health plans Per Month: InsurancePerMonth ________
The following questions ask about household spending on various indicated items **over the past year**. Please write in the amount estimated by the respondent **in the local currency.** If the respondent does not know, please write 'DK'.	
Goods like washing machines, cooking utensils, stove, radio, furniture, purchase of car, motorcycle, or bicycle: GoodsPerYear ________	Repair of vehicles: VehicleRepairPerYear ________
Clothes: ClothesPerYear	Property Management: PropertyManagementPerYear ________
Reimbursement of loans: LoansPerYear ________	Food consumed by the household which is produced/grown in the household: FoodGrownPerYear ________
Heating fuel: HeatingFuelPerYear ________	Other: OtherExpensePerYear ________
Health care costs, excluding any insurance reimbursements: HealthCarePerYear ________	
Household Assets	
Number and area of rooms in your house: Number: NumRooms ________ Area: AreaRooms m^2	Number of bicycles owned: NumBicycles ________
Number of cars owned: NumCars ________	Number of motorcycles/scooters owned: NumMotorcycles ________
What is the source of your drinking water? DrinkingWaterSource 1 Piped in house 2 Public Tap 3 Tube well or well in house 4 Public tube well or well 5 Other	
What type of cooking fuel is used in your house? CookingFuel 1 Gas 2 Electricity 3 Kerosene 4 Wood, paper 6 Coal 5 Other	
What type of toilet facility does your house have? Toilets 1 Private flush toilet 2 Public flush toilet 3 Private pit toilet 4 Public pit toilet 5 Other	
Do you have a washing machine in your house for clothes?	1 Yes 0 No WashingMachine
Do you have a refrigerator in your house?	1 Yes 0 No Refrigerator
Do you have a fixed telephone line in your house?	1 Yes 0 No Telephone
Do you have a mobile phone in your house?	1 Yes 0 No MobilePhone
Do you have a television in your house?	1 Yes 0 No Television
Do you have a radio in your house?	1 Yes 0 No Radio
Do you own livestock (sheep, goats, cows)?	1 Yes 0 No Livestock

Computer

ACS QUIK Seattle Angina Questionnaire v1.0

NORTHWESTERN
UNIVERSITY

A. Patient & Interview Information

The Seattle Angina Questionnaire is completed directly after the MicroEcon Assessment. Patient & Interviewer information do not need to be separately entered into the online electronic data capture. For record keeping purposes please complete the following on the paper form:

~~Last Name:~~ ~~First Name:~~ ~~Middle Name:~~

~~Hospital Patient ID:~~ ACS QUIK ID: ID

~~Hospital Code:~~ ~~Interviewer Name (Paper Form):~~

~~Interview Date (DD/MM/YYYY):~~ ________________ ~~Interview Location:~~ ~~☐Hospital ☐Home ☐Telephone ☐Other:~~ ________________

B. Seattle Angina Questionnaire

The following is a list of activities that people often do during the week. Although for some people with several medical problems it is difficult to determine what it is that limits them, please go over the activities listed below and indicate how much limitation you have had due to chest pain, chest tightness, or angina over the past 4 weeks. Please check only one box per activity.

Activity	Severely Limited	Moderately Limited	Somewhat Limited	A Little Limited	Not Limited	Limited, or did not do for further reasons
Dressing yourself SelfDressing	☐	☐	☐	☐	☐	☐
Walking Indoors on Level Ground WalkingIndoors	☐	☐	☐	☐	☐	☐
Showering Showering	☐	☐	☐	☐	☐	☐
Climbing a hill or flight of stairs without stopping ClimbWithoutStop	☐	☐	☐	☐	☐	☐
Gardening, vacuuming, or carrying groceries Gardening	☐	☐	☐	☐	☐	☐
Walking more than a block at a brisk pace BriskWalkingPace	☐	☐	☐	☐	☐	☐
Running or jogging Running	☐	☐	☐	☐	☐	☐
Lifting or moving heavy objects (e.g. furniture, children) LiftingHeavyObjects	☐	☐	☐	☐	☐	☐
Participating in strenuous sports (e.g swimming, tennis) Sports	☐	☐	☐	☐	☐	☐

Compared with 4 weeks ago, how often do you have chest pain, chest tightness, or angina when doing your most strenuous level of activity? CompairedTo4WeekChestPain

☐1 Much more Often ☐2 Slightly more Often ☐3 About the same ☐4 Slightly less often ☐5 Much less often

Over the past 4 weeks, on average, how many times have you had chest pain, chest tightness, or angina? Past4WeeksAverageChestPainCount

☐1 4 or more times per day ☐2 1-3 times per day ☐3 3 or more times a week but not every day
☐4 1-2 times per week ☐5 Less than once a week ☐6 None over the past 4 weeks

Over the past 4 weeks, on average, how many times have you had to take nitros (nitroglycerin tablets) for your chest pain, chest tightness, or angina? Past4WeeksAverageNitrosIntakeCount

☐1 4 or more times per day ☐2 1-3 times per day ☐3 3 or more times a week but not every day
☐4 1-2 times per week ☐5 Less than once a week ☐6 None over the past 4 weeks

How bothersome is it for you to take your pills for chest pain, chest tightness or angina as prescribed? BothersomeToTakePills

☐1 Very bothersome ☐2 Moderately bothersome ☐3 Somewhat bothersome
☐4 A little bothersome ☐5 Not bothersome at all ☐6 My doctor has not prescribed pills

How satisfied are you that everything possible is being done to treat your chest pain, chest tightness, or angina?

☐1 Not satisfied at all ☐2 Mostly dissatisfied ☐3 Somewhat satisfied ☐4 Mostly satisfied ☐5 Highly satisfied

ChestPainTreatmentSatisfaction

DoctorExplnSatisfaction

How satisfied are you with the explanations your doctor has given you about your chest pain, chest tightness, or angina? ☐1 Not satisfied at all ☐2 Mostly dissatisfied ☐3 Somewhat satisfied ☐4 Mostly satisfied ☐5 Highly satisfied
Overall, how satisfied are you with the current treatment of your chest pain, chest tightness, or angina? OverallTreatmentSatisfaction ☐1 Not satisfied at all ☐2 Mostly dissatisfied ☐3 Somewhat satisfied ☐4 Mostly satisfied ☐5 Highly satisfied
Over the past 4 weeks, how much has your chest pain, chest tightness, or angina interfered with your enjoyment of life? ☐1 It has severely limited my enjoyment of life ☐2 It has moderately limited my enjoyment of life ☐3 It has slightly limited my enjoyment of life ☐4 It has barely limited my enjoyment of life ☐5 It has not limited my enjoyment of life InterferenceOfChestPainOnEnjoyment
If you had to spend the rest of your life with your chest pain, chest tightness, or angina the way it is right now, how would you feel about this? FellOnRestLifeDueToChestPain ☐1 Not satisfied at all ☐2 Mostly dissatisfied ☐3 Somewhat satisfied ☐4 Mostly satisfied ☐5 Highly satisfied
How often do you worry that you may have a heart attack or die suddenly? WorryAboutHeartAttackAndDeath ☐1 I can't stop worrying about this ☐2 I often think or worry about it ☐3 I occasionally worry about it ☐4 I rarely think or worry about it ☐5 I never think or worry about it