**Use this checklist to communicate how angina is affecting your life.**

1. In the past month, how many episodes of angina have you had?

* None
* 1-4
* 5-8
* 9 or more

1. Have you limited or totally given up any activities or work because of your angina?
   * + Yes
     + No
2. Do you ever have angina when you are:
   * + Resting
     + Dressing or bathing
     + Walking at an ordinary pace
     + Walking uphill or quickly
     + Climbing stairs
     + Doing general house/yardwork
     + Having emotional stress
     + Being sexually active
     + Moving heavy objects
     + In hot or cold weather
     + Eating large meals
     + Smoking cigarettes
     + Other:
3. How much angina affected your quality of life? (circle one)

Not at all Somewhat A lot

1 2 3 4 5

1. Do you wish more could be done to reduce your angina?

* Yes
* No

1. Is there anything else you’d like your doctor to know?
2. What other topics do you want to discuss with your doctor?
   * + Managing side effects
     + Treatment options
     + Diet and exercise
     + Other: