**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: