

## The Seattle Angina Questionnaire-7

1. 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**.

Place an X in one box on each line.

Activity	Extremely limited	Quite a bit limited	Moderately Limited	Slightly limited	Not at all limited	Limited for other reasons or did not do the activity
a. Walking indoors on level ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Gardening, vacuuming or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lifting or moving heavy objects (e.g. furniture, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

I have had **chest pain, chest tightness or angina**...

4 or more times per day	1-3 times per day	3 or more times per week but not every day	1-2 times per week	Less than once a week	None over the past 4 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

I have taken nitroglycerin...

4 or more times per day	1-3 times per day	3 or more times per week but not every day	1-2 times per week	Less than once a week	None over the past 4 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Over the past 4 weeks, how much has your **chest pain, chest tightness or angina** limited your enjoyment of life?

It has <b>extremely</b> limited my enjoyment of life	It has limited my enjoyment of life <b>quite a bit</b>	It has <b>moderately</b> limited my enjoyment of life	It has <b>slightly</b> limited my enjoyment of life	It has <b>not</b> limited my enjoyment of life at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. 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?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>