Supplementary Online Content


eSurvey. Bicuspid Aortic Valve Follow-up Survey

This supplementary material has been provided by the authors to give readers additional information about their work.
Bicuspid Aortic Valve Follow-Up Survey

Survey Research Center

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Please enter any missing information or change any that is incorrect.

Directions: All questions are in relation to the diagnosis of bicuspid aortic valve noted above. Answer each question as best you can by checking the appropriate box or filling in the blanks.

16-23

Today's Date: __/__/____

1. How would you rate your general health?
   1 ☐ Excellent       2 ☐ Good       3 ☐ Fair       4 ☐ Poor

2. At the present time, are you limited in your normal daily activities?
   1 ☐ No       2 ☐ Yes

3. Are you as active as you would like to be?
   1 ☐ No       2 ☐ Yes

4. Do you believe you are limited in your daily activities because of your heart condition?
   1 ☐ No       2 ☐ Yes

   If yes, please explain how you are limited.
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

Page 1
5. Do you have shortness of breath:
   with marked exertion?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

   with daily activities?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

   with minimal exertion?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

   at rest?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

6. Do you have chest pain:
   with marked exertion?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

   with daily activities?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

   with minimal exertion?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

   at rest?
   1 □ No  2 □ Yes
   If yes, please note the date that this first occurred.
   Month / Day / Year

7. Since the echocardiogram noted on page 1, have you had a heart attack
   (myocardial infarction)?
   1 □ No  2 □ Yes
   When did you have this heart attack? ______ / ______ / ______
   Month  Day  Year

   Were you seen by a doctor or treated at a hospital for this heart attack?
   1 □ No  2 □ Yes

   If you were seen by a doctor or treated at a facility other than
   Mayo Clinic, St. Marys, or Rochester Methodist Hospital in
   Rochester, Minnesota, please record:

   Name of Doctor or Hospital

   City  State
8. Since the echocardiogram noted on page 1, have you had any problems with:

**shortness of breath?**

   1 □ No  2 □ Yes

   If yes, after walking how many blocks?  
   ____ block(s)

   After climbing how many flights of stairs?  
   ____ flight(s) of stairs

**swelling of your ankles or abdomen?**

   1 □ No  2 □ Yes

   On an average, how many days per week?  
   ____ days per week

**chest pain?**

   1 □ No  2 □ Yes

   How often does this chest pain occur in a month?  
   ____ times a month

   What brings on the chest pain?  
   __________________________

**blood clot?**

   1 □ No  2 □ Yes

   When did it occur?  
   /  /  /
   Month  Day  Year

   What part of the body did it affect?  
   __________________________

   If you were seen by a doctor or treated at a facility other than Mayo Clinic, St. Marys, or Rochester Methodist Hospital in Rochester, Minnesota, please record:

   Name of Doctor or Hospital  
   __________________________

   City  State  
   __________________________
9. Since the echocardiogram noted on page 1, have you been hospitalized because of your heart problem?

1 □ No 2 □ Yes

If you have been hospitalized other than at St. Marys or Rochester Methodist Hospital in Rochester, Minnesota, please record:

Name of Doctor or Hospital

City State

Date of hospitalization: ___/___/____

Month Day Year

Reason for hospitalization:

10. Since the echocardiogram noted on page 1, have you had any episodes of bleeding for which you saw a doctor or were hospitalized?

1 □ No 2 □ Yes

Where on your body did the bleeding occur?

Please rate how severe the worst stroke was.

1 □ Very severe 2 □ Severe 3 □ Somewhat 4 □ Not at all severe

If you were seen by a doctor or treated at a facility other than Mayo Clinic, St. Marys, or Rochester Methodist Hospital in Rochester, Minnesota, please record.

Name of Doctor or Hospital

City State

11. Since the echocardiogram noted on page 1, have you had any episodes of strokes for which you saw a doctor or were hospitalized?

1 □ No 2 □ Yes

Please rate how severe the worst stroke was.

1 □ Very severe 2 □ Severe 3 □ Somewhat 4 □ Not at all severe

If you were seen by a doctor or treated at a facility other than Mayo Clinic, St. Marys or Rochester Methodist Hospital in Rochester, Minnesota, please record.

Name of Doctor or Hospital

City State
12. Since the echocardiogram noted on page 1, have you had a heart catheterization?

1 □ No  2 □ Yes

If the heart catheterization was performed at a hospital other than St. Marys or Rochester Methodist Hospital in Rochester, Minnesota, please record:

Name of Doctor or Hospital

City

State

Date of echocardiogram: _____/_____/______

Month Day Year

13. Since the echocardiogram noted on page 1, have you had more echocardiograms?

1 □ No  2 □ Yes

If the echocardiogram was performed at a facility other than Mayo Clinic, St. Marys, or Rochester Methodist Hospital in Rochester, Minnesota, please record:

Echocardiogram #1

Name of Doctor or Hospital

City

State

Date of echocardiogram: _____/_____/______

Month Day Year

If you have had any other echocardiograms performed at a facility other than Mayo Clinic, St. Marys or Rochester Methodist Hospital in Rochester, Minnesota, please record:

Echocardiogram #2

Name of Doctor or Hospital

City

State

Date of echocardiogram: _____/_____/______

Month Day Year
14. Since the echocardiogram noted on page 1, have you had a balloon dilatation procedure for the heart arteries (coronary angioplasty) performed?

1 □ No 2 □ Yes

If the balloon procedure was performed at a facility other than Mayo Clinic, St. Marys, or Rochester Methodist Hospital in Rochester, Minnesota, please record.

Name of Doctor or Hospital

City State

Date of coronary angioplasty: ___/___/____
Month Day Year

15. Since the echocardiogram noted on page 1, have you had any heart surgery?

1 □ No 2 □ Yes

If this surgery was performed at a hospital other than St. Marys or Rochester Methodist Hospital in Rochester, Minnesota, please record.

Name of Doctor or Hospital

City State

What kind of heart surgery?

Date of heart surgery: ___/___/____
Month Day Year

16. Since the echocardiogram noted on page 1, have you had an aortic aneurysm (enlargement of main blood vessel) or aortic dissection (tearing of aortic wall)?

1 □ No 2 □ Yes

If this diagnosis was made at a hospital other than St. Marys or Rochester Methodist Hospital in Rochester, Minnesota, please record.

Name of Doctor or Hospital

City State

Where was the aneurysm?

Date of aortic aneurysm and/or aortic dissection:

___/___/____
Month Day Year

How was this treated? 1 □ Surgically 2 □ Medically
17. Since the echocardiogram noted on page 1, have you had infection of your heart or heart valves (infectious endocarditis)?
   1 □ No  2 □ Yes
   
   If this treatment was performed at a hospital other than St. Marys or Rochester Methodist Hospital in Rochester, Minnesota, please record.
   
   Name of Doctor or Hospital

   City  State

   Which valve was affected?  1 □ Aortic  3 □ Tricuspid
   2 □ Mitral  4 □ Don’t know

   Date of treatment: ___/___/____
   Month  Day  Year

   How was this treated?  1 □ Surgically  2 □ Medically

18. Have you had trouble with:
   
   irregular heartbeat (atrial fibrillation)?  1 □ No  2 □ Yes
   
   rapid heartbeat (tachycardia)?  1 □ No  2 □ Yes
   
   fluid in the lungs (pulmonary edema)?  1 □ No  2 □ Yes
   
   fainting spells?  1 □ No  2 □ Yes
   
   near-fainting or light-headedness?  1 □ No  2 □ Yes
   
   heart pounding (palpitations or irregular beat)?  1 □ No  2 □ Yes
   
   infection of the heart or heart valve?  1 □ No  2 □ Yes

19. Please list all medications you are currently taking.
   
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

   We welcome any further comments that might help us better understand how you have been getting along since your heart surgery.

   Thank you!