SINGHEART Patient Questionnaire

DEMOGRAPHICS

1) Race?

☐Chinese □Malay □Indian □Others: _____

2) Country of birth?

□Singapore □Others: _____

3) Marital status?

□Married □Single □Widowed □Separated/divorced

4) Religion?

□Free thinker □Christian/Catholic □Buddhist □Taoist □Islam □Hindu

□Judaism □Others:_____

5) Highest education level?

□ No formal education □Primary □Secondary/High school □Polytechnic

□ITE □A-Level □Degree/University or higher

6) Type of housing currently living in

□1 or 2 Room HDB: □Owned or □ Rented?

□3 Room HDB: □Owned or □ Rented?

□4 Room HDB: □Owned or □ Rented?

□5 Room HDB □Owned or □ Rented?

□HUDC: □Owned or □ Rented?

□Condominium: □Owned or □ Rented?

□Landed property: □Owned or □ Rented?

□Others: _____ : □Owned or □ Rented?

7) Occupation?

□Unemployed/retired □Blue collared (involving manual labour)

□White collared (office work, professionals) □Pink collared (service industry)

8) Monthly income?

□<$1000/Not working □$1000-1999 □$2000-2999 □$3000-4999

□$5000-6999 □$7000-8999 □$9000 and more

9) How many siblings?

___ brother(s) ___ sister(s)

10 How many children?

___ son(s) ___ daughter(s)

MEDICAL HISTORY

11) Do you have a family history (siblings OR father/mother OR children) of: (tick all that apply)

□Diabetes	Who? _____	What age?_____
□Hypertension (high blood pressure)	Who? _____	What age?_____
□Hyperlipidemia (high cholesterol)	Who? _____	What age?_____
□Heart attack/heart blockage	Who? _____	What age?_____
□Heart failure	Who? _____	What age?_____
□Other heart disease: (specify:_____)	Who? _____	What age?_____
□Sudden unexpected death	Who? _____	What age?_____

12) Do you have any of the following medical conditions (tick all that apply)

□Coronary artery disease	Duration _____ (years)
□Heart attack	Duration _____ (years)
□Previous stenting	Duration _____ (years)
□Previous coronary artery bypass	Duration _____ (years)
□Heart failure	Duration _____ (years)
□Previous stroke	Duration _____ (years)
□Diabetes mellitus	Duration _____ (years)
□Hypertension (high blood pressure)	Duration _____ (years)
□Hyperlipidemia (high cholesterol)	Duration _____ (years)
□Cancer, please specify: _____	Duration _____ (years)

□Asthma Duration _____ (years)

□Kidney failure on dialysis Duration _____ (years)

□Chronic lung disease Duration _____ (years)

□Hepatitis B/C Duration _____ (years)

□Others, please specify: _____ Duration _____ (years)

SMOKING

13) Do you currently smoke?

□Yes (___ pack/day x ___years)

□Previously (___ pack/day x ___years) but stopped for □<6m □ ≥6m

□No

14) On average, how many of the following do you smoke a day? (tick all that apply)

□Cigarettes ____/day

□Ang hoon ____/day

□Pipes ____/day

□Cigars ____/day

15) What is highest number of cigarettes smoked a day?

_____

16) Are you currently exposed to cigarette smoke at home?

□Never □Sometimes □Most of the time □All the time

17) Are you currently exposed to cigarette smoke at work?

□Never □Sometimes □Most of the time □All the time

ALCOHOL

18) Have you consumed alcohol within the past 3 months?

□Yes (___ units per week)

□No

(1 unit= half pint of beer, small glass of wine or shot of spirit/hard liquor)

19) How often in the last year did you drink the following alcoholic beverages? (tick all that apply)

□Beer can _____ per week

□Beer bottle _____ per week

□Red wine _____ glasses per week

□White wine _____ glasses per week

□Sparkling wine _____ glasses per week

□Hard liquor _____ glasses per week

TRADITIONAL/COMPLEMENTARY MEDICINE

20) Do you use Traditional medicines/complementary medicines?

□Yes

□No

21) On average, how many times **a month** do you use traditional/complimentary medicines?

____ times

22) What type of traditional/complementary medicines do you use? (tick all that apply)

□Traditional Chinese medicine

□Acupuncture

□Jamu/Traditional Malay medicine

□Traditional Indian medicine

□Relaxation therapies: yoga, meditation

□Herbal remedies: garlic, ginger, ginkgo biloba etc

□Vitamins

□Massages

□Chiropractic

□Tai chi or chi gong

□Magnetic therapy

□Others: _____

EXERCISE

23) How often do you exercise a week?

□Never/hardly (ie. not even once a week on average)

□ ___ times for ____ min each time

Please specify type of exercise: _____

DIET

24) How much coffee do you drink a week?

□ never or rarely □ <1 cup a week

□ ≥1 cup a week but <1 daily □___ cups a day

(tick all that apply) □with milk? □with sugar?

25) How much English tea do you drink a week?

□ never or rarely □ <1 cup a week

□ ≥1 cup a week but <1 daily □___ cups a day

(tick all that apply) □with milk? □with sugar?

26) How much Chinese tea do you drink a week?

□ never or rarely □ <1 cup a week

□ ≥1 cup a week but <1 daily □___ cups a day

(tick all that apply) □with milk? □with sugar?

27) How much Green tea do you drink a week?

□ never or rarely □ <1 cup a week

□ ≥1 cup a week but <1 daily □___ cups a day

(tick all that apply) □with milk? □with sugar?

28) How many servings of vegetables do you take a day?

_____ servings

(eg. 1 serving is ¾ mug cooked leafy or non-leafy vegetables (100g)/ ¼ round plate of cooked vegetables/150g raw leafy vegetables/100g raw non-leafy vegetables)

29) How many servings of fruits do you take a day?

_____ servings

(one serving is1 small apple, orange, pear or mango/1 wedge of pineapple, papaya or watermelon/10 grapes or longans (50g)/1 medium banana)

PERCEPTIONS

30) How active do you think your lifestyle is? (Circle your answer)

1	2	3	4	5	6	7	8	9	10
Not active → **Very active**									

31) In general, how stressed do you feel? (Circle your answer)

1	2	3	4	5	6	7	8	9	10
Not stressed → **Very stressed**									

Health Questionnaire

English version for Singapore

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems in walking about ❑

I have some problems in walking about ❑

I am confined to bed ❑

Self-Care

I have no problems with self-care ❑

I have some problems washing or dressing myself ❑

I am unable to wash or dress myself ❑

Usual Activities *(e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ❑

I have some problems with performing my usual activities ❑

I am unable to perform my usual activities ❑

Pain / Discomfort

I have no pain or discomfort ❑

I have moderate pain or discomfort ❑

I have extreme pain or discomfort ❑

Anxiety / Depression

I am not anxious or depressed ❑

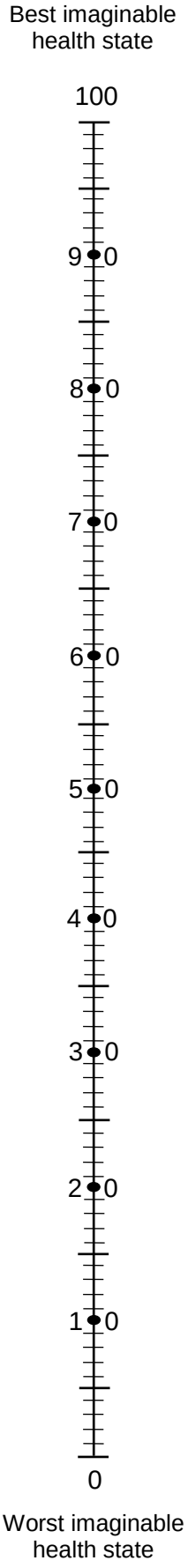
I am moderately anxious or depressed ❑

I am extremely anxious or depressed ❑

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the **BLACK BOX** below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



Subject's Initials_____ID#_____Date_____Time_____AM PM

PITTSBURGH SLEEP QUALITY INDEX

INSTRUCTIONS:
The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

   BED TIME _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

   NUMBER OF MINUTES _____

3. During the past month, what time have you usually gotten up in the morning?

   GETTING UP TIME _____

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

   HOURS OF SLEEP PER NIGHT _____

For each of the remaining questions, check the one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you . . .

a) Cannot get to sleep within 30 minutes

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

b) Wake up in the middle of the night or early morning

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

c) Have to get up to use the bathroom

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

d) Cannot breathe comfortably

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

e) Cough or snore loudly

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

f) Feel too cold

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

g) Feel too hot

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

h) Had bad dreams

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

i) Have pain

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

j) Other reason(s), please describe_____

_____

How often during the past month have you had trouble sleeping because of this?

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

6. During the past month, how would you rate your sleep quality overall?

Very good _____

Fairly good _____

Fairly bad _____

Very bad _____

7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all _____

Only a very slight problem _____

Somewhat of a problem _____

A very big problem _____

10. Do you have a bed partner or room mate?

No bed partner or room mate _____

Partner/room mate in other room _____

Partner in same room, but not same bed _____

Partner in same bed _____

If you have a room mate or bed partner, ask him/her how often in the past month you have had . . .

a) Loud snoring

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

b) Long pauses between breaths while asleep

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

c) Legs twitching or jerking while you sleep

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

d) Episodes of disorientation or confusion during sleep

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

e) Other restlessness while you sleep; please describe_____

_____

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

Buysse DJ, Reynolds CF, Monk TH, Berman SR, Kupfer DJ: Psychiatry Research, 28:193-213, 1989.

For Men Only

International Index of Erectile Function (IIEF)

Please use an X where applicable and be sure to initial and date all corrections

Score 0 if not done Subject questionnaire Section 1

Instructions: These questions ask about the effects your erection problems have had on your sex life, over the past 4 weeks. Please answer the following questions as honestly and clearly as possible. In answering these questions, the following definitions apply:

Definitions:

- *Sexual activity includes intercourse, caressing, foreplay and masturbation*
- *Sexual intercourse is defined as vaginal penetration of the partner (you entered the partner)*
- *Sexual stimulation includes situations like foreplay with a partner, looking at erotic pictures, etc.*
- *Ejaculate is defined as the ejection of semen from* the penis (or the feeling of this)

Mark ONLY one circle per question:

1. Over the past 4 weeks, how often were you able to get an erection during sexual activity?

□ No sexual activity
□ Almost always or always
□ Most times (much more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

2. Over the past 4 weeks, when you had erections with sexual stimulation, how often were your erections hard enough for penetration?

□ No sexual stimulation
□ Almost always or always
□ Most times (much more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

Questions 3, 4 and 5 will ask about erections you may have had during sexual intercourse.

3. Over the past 4 weeks, when you attempted sexual intercourse, how often were you able to penetrate (enter) your partner?

□ Did not attempt intercourse
□ Almost always or always
□ Most times (much more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

4. Over the past 4 weeks, during sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

□ Did not attempt intercourse
□ Almost always or always
□ Most times (much more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

5. Over the past 4 weeks, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

□ Did not attempt intercourse
□ Extremely difficult
□ Very difficult
□ Difficult
□ Slightly difficult
□ Not difficult

6. Over the past 4 weeks, how many times have you attempted sexual intercourse?

□ No attempts
□ 1-2 attempts
□ 3-4 attempts
□ 5-6 attempts
□ 7-10 attempts
□ 11 or more attempts

7. Over the past 4 weeks, when you attempted sexual intercourse how often was it satisfactory for you?

□ Did not attempt intercourse
□ Almost always or always
□ Most times (much more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

8. Over the past 4 weeks, how much have you enjoyed sexual intercourse?

□ No intercourse
□ Very highly enjoyable
□ Highly enjoyable
□ Fairly enjoyable
□ Not very enjoyable
□ Not enjoyable

9. Over the past 4 weeks, when you had sexual stimulation or intercourse how often did you ejaculate?

□ Did not attempt intercourse
□ Almost always or always
□ Most times (more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

10. Over the past 4 weeks, when you had sexual stimulation or intercourse how often did you have the feeling of orgasm or climax (with or without ejaculation)?

□ No sexual stimulation or intercourse
□ Almost always or always
□ Most times (much more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

Questions 11 and 12 ask about sexual desire. Let's define sexual desire as a feeling that may include wanting to have a sexual experience (for example, masturbation or intercourse), thinking about having sex or feeling frustrated due to a lack of sex.

11. Over the past 4 weeks, how often have you felt sexual desire?

□ Almost always or always
□ Most times (much more than half the time)
□ Sometimes (about half the time)
□ A few times (much less than half the time)
□ Almost never or never

12. Over the past 4 weeks, how would you rate your level of sexual desire?

□ Very high
□ High
□ Moderate
□ Low
□ Very low or none at all

13. Over the past 4 weeks, how satisfied have you been with you overall sex life?

□ Very satisfied
□ Moderately satisfied
□ About equally satisfied and dissatisfied
□ Moderately dissatisfied
□ Very dissatisfied

14. Over the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?

□ Very satisfied
□ Moderately satisfied
□ About equally satisfied and dissatisfied
□ Moderately dissatisfied
□ Very dissatisfied

15. Over the past 4 weeks, how do you rate your confidence that you can get and keep your **erection**?

□ Very high
□ High
□ Moderate
□ Low
□ Very low