

# QUESTIONNAIRE ON EXPECTATIONS BEFORE CORONARY ANGIOGRAPHY

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**Information about the questionnaire:**

By answering these questions you will help us **find out what expectations you have for your upcoming examination, care and treatment.**

Instructions on how you should complete the questionnaire:

**Answer the questions by placing a cross in the box next to the statement that you feel best describes your case. If you are unsure, select the option that is closest.**

**1. What is, in your opinion, the main reason for you to undergo a coronary angiography?**

**Answer only ONE of the following options.**

a. To investigate whether there are changes in my heart that could pose a risk for my future life.	<input type="checkbox"/>
b. To investigate what is causing my symptoms (shortness of breath, palpitations, pain / pressure in the chest, etc).	<input type="checkbox"/>
c. To investigate whether any intervention (angioplasty or bypass surgery) can be performed to make my symptoms disappear.	<input type="checkbox"/>
d. To investigate whether my heart is healthy enough for me to undergo other planned surgery (not on the heart).	<input type="checkbox"/>
e. I will be investigated prior to undergoing heart valve surgery	<input type="checkbox"/>

**2. What do the symptoms or the clinical findings that have prompted the planned coronary examination mean to you?**

*Answer ALL the questions below, a-g, with the option that best applies to you*

	Agree entirely	Agree almost entirely	Agree partially	Completely disagree
a. I have no symptoms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My symptoms do not affect me much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My symptoms are limiting my ability to live an active life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My symptoms are of a physical nature.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My relatives are worried.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My relationships with family and friends are affected.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I am worried about my future health and survival.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## 3. What do you expect the coronary examination to show?

**Answer only ONE of the following options.**

- |  |                          |
|--|--------------------------|
| a. That there is no narrowing of the coronary vessels.   | <input type="checkbox"/> |
| b. That there is narrowing of the coronary vessels, but not worse than that lifestyle changes (consisting of e.g. smoking cessation, physical exercise and dietary changes) will suffice as treatment. | <input type="checkbox"/> |
| c. That there is narrowing of the coronary vessels that may explain my symptoms and that the appropriate treatment will be with drugs.   | <input type="checkbox"/> |
| d. That there is narrowing of the coronary vessels that can be appropriately treated with balloon angioplasty.   | <input type="checkbox"/> |
| e. That there is narrowing of the coronary vessels that is suitable for treatment with bypass surgery.   | <input type="checkbox"/> |
| f. That there is narrowing of my coronary vessels that cannot be treated with any of the above options.  | <input type="checkbox"/> |

## 4. Do you have symptoms such as palpitations, shortness of breath or pain / pressure in the chest?

- |   |                          |
|---|--------------------------|
| <b>No</b> If No, skip the remaining parts of question 4 and go on to question 5 → | <input type="checkbox"/> |
| <b>Yes</b> If Yes, answer the question below:                                     | <input type="checkbox"/> |

## b. Can you imagine living with your symptoms, if they do not pose an increased risk for your future life and health?

- |   |                          |
|---|--------------------------|
| <b>Yes</b> If Yes, skip the remaining parts of question 4 and go on to question 5 → | <input type="checkbox"/> |
| <b>No</b> If No, answer the question below:   | <input type="checkbox"/> |

**No, I cannot imagine living with these symptoms because:**

**(Choose ONE of the following options, the one which is the most important for you)**

- |   |                          |
|---|--------------------------|
| c. They do not allow me to exert myself physically. | <input type="checkbox"/> |
| d. They make me worry.                              | <input type="checkbox"/> |
| e. They remind me of being ill.                     | <input type="checkbox"/> |

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*If coronary angiography shows that you have narrowing of your coronary vessels*

**5. What best describes your attitude towards the choice of treatment?**

**Answer only ONE of the following options.**

- |   |                          |
|---|--------------------------|
| a. I have a fixed opinion about which treatment I prefer.   | <input type="checkbox"/> |
| b. I want to be informed about the different treatment options available and then decide together with the responsible cardiologist which treatment I will receive. | <input type="checkbox"/> |
| c. I want the responsible cardiologist to decide which treatment I will receive.  | <input type="checkbox"/> |

*If coronary angiography shows that you have narrowing of your coronary vessels*

**6. Which of the following treatment options would you then prefer?**

**Answer only ONE of the following options.**

- |   |                          |
|---|--------------------------|
| a. I would prefer lifestyle changes (consisting of e.g. smoking cessation, physical exercise and dietary changes) | <input type="checkbox"/> |
| b. I would prefer only medical treatment  | <input type="checkbox"/> |
| c. I would prefer angioplasty   | <input type="checkbox"/> |
| d. I would prefer bypass surgery  | <input type="checkbox"/> |

**7. What is your view on changing your lifestyle** (consisting of e.g. smoking cessation, physical exercise and dietary changes)?

**Answer only ONE of the following options.**

- |  |                          |
|--|--------------------------|
| a. I would prefer to start with lifestyle changes and resort to another treatment later if it becomes necessary. | <input type="checkbox"/> |
| b. I would prefer lifestyle changes only as a complement to other treatment.                                     | <input type="checkbox"/> |
| c. I do not want to make any lifestyle changes.  | <input type="checkbox"/> |
| d. I have already done everything possible in terms of lifestyle changes.  | <input type="checkbox"/> |

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**8. What is your view on a lifelong medical treatment consisting of anti-thrombotic, lipid-lowering and cardioprotective drugs?**

**Answer only ONE of the following options.**

- |  |                          |
|--|--------------------------|
| a. I do not want any medical treatment.  | <input type="checkbox"/> |
| b. I can imagine being treated with drugs for a limited time (treatment duration of about one year). | <input type="checkbox"/> |
| c. I can imagine lifelong medical treatment.   | <input type="checkbox"/> |

**9. Some questions about information and availability**

**Answer ALL the questions below, a-g, with the option that best applies to you**

	Agree entirely	Agree almost entirely	Agree partially	Completely disagree
a. I trust that I will receive all necessary information before any future treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I trust that I will receive the treatment that my condition requires.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I trust that I will receive the treatment that I need in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I trust that I will be well received (by medical staff) in connection with the examination, health care and treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I trust that I will be able to feel safe in connection with the examination, health care and treatment that I receive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. Do you think that your present state will be affected by the treatment you will possibly receive after coronary angiography?**

**Answer only ONE of the following options.**

- |   |                          |
|---|--------------------------|
| a. I expect to be completely recovered.<br>I hope to be completely fine.                            | <input type="checkbox"/> |
| b. I expect to be almost completely recovered.<br>I hope to improve even if I am not entirely fine. | <input type="checkbox"/> |
| c. I expect to be only partially recovered.<br>I hope to get somewhat better.                       | <input type="checkbox"/> |
| d. I expect no improvement at all.<br>I have no hopes of getting better.                            | <input type="checkbox"/> |

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## 11. What possible result of the examination and treatment is most important for you?

*Rank the following options from 1 to 6, write 1 for the most important option, 2 for the second most important, and so on.*

a. To be completely free of symptoms.	<input type="checkbox"/>
b. To live a normal life and be able to perform desirable activities.	<input type="checkbox"/>
c. To have a good knowledge about my symptoms / condition.	<input type="checkbox"/>
d. To know whether my symptoms / condition present a risk for my future life and health.	<input type="checkbox"/>
e. To obtain relief from my symptoms.	<input type="checkbox"/>
d. To reduce anxiety and increase a feeling of safety	<input type="checkbox"/>

**Thank you for your participation!**