Atrial Fibrillation Symptoms Questionnaire (AFS)

The following questions ask about how often you experience atrial fibrillation or irregular heartbeat symptoms over the **past 7 days**. Please mark with an "X" how often you have the symptom. Please choose only one box per question.

IN THE PAST 7 DAYS…	**All of the time**	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**Hardly any of the time**	**None of the time**
1. How often did you feel your heart **pounding**?	☐	☐	☐	☐	☐	☐	☐
2. How often did you feel **chest pain**?	☐	☐	☐	☐	☐	☐	☐
3. How often did you feel your heart **racing**?	☐	☐	☐	☐	☐	☐	☐
4. How often did you **feel weak**?	☐	☐	☐	☐	☐	☐	☐
5. How often did you **feel tired**?	☐	☐	☐	☐	☐	☐	☐
6. How often did you **feel dizzy**?	☐	☐	☐	☐	☐	☐	☐
7. How often did you have an **irregular heartbeat**?	☐	☐	☐	☐	☐	☐	☐
8. How often did you feel your **heartbeat skipping**?	☐	☐	☐	☐	☐	☐	☐
9. How often did you feel **a lack of energy**?	☐	☐	☐	☐	☐	☐	☐
10. How often did you have a **feeling of pressure** in your chest?	☐	☐	☐	☐	☐	☐	☐
11. How often did you have **shortness of breath** during normal daily activities?	☐	☐	☐	☐	☐	☐	☐