my **symptom** tracker

Date ____/____/____

my ATTR roadmap

Use this page to record the day-to-day symptoms you're experiencing. **Fill it out, jot down any notes or questions for your doctor, and bring it to your next appointment.**

If you're experiencing the symptoms listed below or think you may have ATTR amyloidosis, visit **myATTRroadmap.com** for more detailed information.

This symptom tracker is not a substitute for reporting symptoms to your doctor. Report any symptoms that concern you right away.

Fill out in 5 easy steps

START

1. **Select your symptoms**
2. Indicate the **severity** on a scale from 1 to 5, with 5 being severe
3. When filling out the symptom tracker, indicate if, in the past month, your symptoms have:
   - **I** - Improved
   - **S** - Stayed the same
   - **W** - Worsened
4. Write down the **dates** you've experienced these symptoms
5. Indicate the **impact on daily life:**
   - **A)** Difficulty with daily activities, including work
   - **B)** Reduced social interaction
   - **C)** Reduced physical activity (eg, walking, lifting)
   - **D)** Reduced emotional well-being

☑ Example symptom	1 2 (3) 4 5	I S (W)	6/3 - 7/3	A B (C) D

Symptoms in the hands, arms, legs, and feet

☐ Tingling or pain in your hands or feet	1 2 3 4 5	I S W	/ - /	A B C D
☐ Aching pain in both hands and/or forearms	1 2 3 4 5	I S W	/ - /	A B C D
☐ Reduced grip	1 2 3 4 5	I S W	/ - /	A B C D
☐ Loss of sensitivity to touch or temperature	1 2 3 4 5	I S W	/ - /	A B C D
☐ Numbness or weakness in the legs and feet	1 2 3 4 5	I S W	/ - /	A B C D
☐ Difficulty walking or moving around	1 2 3 4 5	I S W	/ - /	A B C D

Symptoms related to the heart, blood vessels, and circulation

☐ Abnormal heartbeat	1 2 3 4 5	I S W	/ - /	A B C D
☐ Shortness of breath	1 2 3 4 5	I S W	/ - /	A B C D
☐ Fatigue	1 2 3 4 5	I S W	/ - /	A B C D
☐ Swelling in the feet or ankles	1 2 3 4 5	I S W	/ - /	A B C D
☐ Dizziness upon standing	1 2 3 4 5	I S W	/ - /	A B C D
☐ Lightheadedness	1 2 3 4 5	I S W	/ - /	A B C D

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Symptoms related to digestion, nutrition, and weight				
❑ Diarrhea	1 2 3 4 5	I S W	/ – /	A B C D
❑ Constipation	1 2 3 4 5	I S W	/ – /	A B C D
❑ Loss of bowel or bladder control	1 2 3 4 5	I S W	/ – /	A B C D
❑ Reduced appetite	1 2 3 4 5	I S W	/ – /	A B C D
❑ Unintended weight loss	1 2 3 4 5	I S W	/ – /	A B C D

Other symptoms				
❑ Blurry vision	1 2 3 4 5	I S W	/ – /	A B C D
❑ Eye floaters	1 2 3 4 5	I S W	/ – /	A B C D
❑ Sexual dysfunction	1 2 3 4 5	I S W	/ – /	A B C D
❑ Anxiety and/or depression	1 2 3 4 5	I S W	/ – /	A B C D

Use the space below to write any additional notes, such as:

- Additional symptoms not captured in the spaces above
- More details about symptoms and their impact on daily life
- Questions for your healthcare team

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