

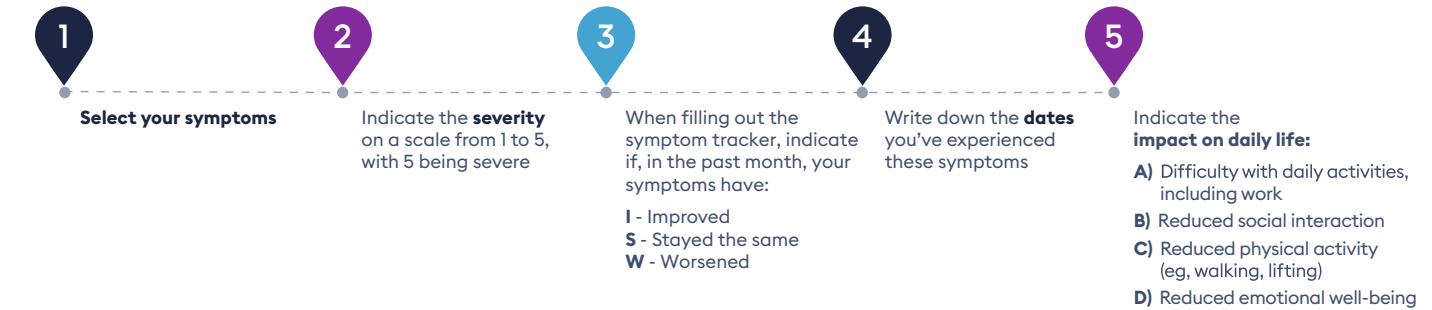
Use this page to record the day-to-day symptoms you're experiencing. **Fill it out, jot down any notes or questions for your doctor, and bring it to your next appointment.**

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



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

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

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