Assessment questionnaire:

- [ ] 1. ONSET.
When did the pain begin? What was the patient doing?
- [ ] 2. LOCATION.
Where (on the body) does the patient feel pain?
- [ ] 3. DURATION.
How long does the pain last?
- [ ] 4. CHARACTERISTICS OF THE PAIN.
How does it feel? The patient should describe the pain in terms like stabbing, dull, crushing or indigestion-like.
- [ ] 5. ASSOCIATING FACTORS.
Are there other symptoms associated with chest pain? Has the patient experienced (in addition to the pain) nausea and/or vomiting, breathlessness, weakness, diaphoresis, fatigue, syncope, cold and clammy hands?
- [ ] 6. RELIEVING FACTORS.
Does the pain radiate down the arm or up the neck or both?
- [ ] 7. TREATMENT.
Was a treatment procedure such a glyceryl trinitrate (GTN) spray used? Was the pain relieved through its use? Does the patient report that the pain subsides if he ceases physical activity, takes a rest or sits forward?
- [ ] 8. SEVERITY (INTENSITY).
How bad/severe is the pain? The patient should grade his pain on a scale of 0 to 10 (0 being no pain and 10 excruciating pain/the worst pain experienced).

Interpretation of answers (in the same numerical order) with additional information:

1. Ischaemic chest pain is usually acute and occurs with exertion and subsides with rest.

2. Ischaemic pain may be felt in other areas of the body besides the chest, from the pubis region to the top of the head (19).

3. If the pain is continuous or prolonged (e.g. after exercise) it is unlikely to be cardiac related. Also, pain that comes rapidly and goes nearly just as fast, usually in less than a minute, is unlikely to be caused by cardiac issues. Ischaemic chest pain usually lasts longer, up to 20 minutes (20).

4. Pain that is reproducible on palpation, sharp or pleuritic and/or is worse on inhalation or coughing is unlikely to be cardiac in nature, although that cannot be excluded. Typical angina pectoris is generally defined as chest discomfort that gets worse with physical exertion, but that might not necessarily be the case in asymptomatic patients.

5. Presentation of nausea, vomiting, breathlessness, diaphoresis, syncope or presyncope in addition to chest pain is indicative of probable MI.

6. A radiating pattern of ischaemic chest pain often extends to the left arm, neck and jaw (19).

7. Pain mitigated through rest and the use of GTN is likely ischaemic. Pain relieved through changes in body position or respiratory change is, on the other hand, unlikely to be cardiac related.

8. Pain severity does not accurately correlate with the likelihood of MI or other cardiac issues, but should nevertheless be noted as it can be indicative of other serious conditions (like aortic dissection) (21).

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