Preferred contact phone #: _____ Email: _____
Occupation past/present: _____ Phone: _____
Are you: **Full Time** **Part Time** **Retired** **On sick leave** **Other**
If on sick leave, when do you plan to return to work? _____

Primary Care Doctor: _____ Phone: _____

Cardiologist/Surgeon: _____ Phone: _____

In the event of cardiac or respiratory arrest, would you like us to start resuscitation efforts? **Yes** **No**
If not, do you have a DNR order already in place? **Yes** **No**
Do you feel safe where you live? **Yes** **No** Have you been hurt or neglected in the past year? **Yes** **No**
Who do you rely on for physical and emotional support? _____

Please circle and date any of the following conditions/procedures you have had, list other surgeries:

Heart Attack	Date: _____	**Pacemaker/Defibrillator**: _____	
Bypass Surgery	Date: _____	**Arrhythmia**: _____	
Angina	Date: _____	**Other Past Surgeries/Diagnosis:**	
Angioplasty/Stent	Date: _____	Diagnosis/Date: _____	
Valve Surgery	Date: _____	Diagnosis/Date: _____	
Heart Transplant	Date: _____	Diagnosis/Date: _____	

Risk Factors: Check box if answer is YES, circle **bolded** options, and fill in blanks the best you can.

- ☐ Tobacco: **Cigarettes Cigar Pipe Chew** ____Packs/Day _____Start date ____Quit date ____years used
- ☐ High blood pressure
- ☐ High cholesterol: Total Cholesterol:_____ Triglycerides:_____ LDL:_____ HDL:_____
- ☐ Diabetes: Fasting BS:___ BS Range: _____ HgA1C:_____ Times/day checked____
- ☐ Overweight: Ideal Weight:_____
- ☐ Family History of Heart Disease:_____
- ☐ Stress: Describe sources of stress:_____
- ☐ Alcohol: **Wine Beer Liquor** _____Drinks/day _____Days/week
- ☐ Current Level of Exercise: Type:_____ Minutes:_____ Days/Week:_____

On a scale of 0-10 (10 is high), how much is depression a part of your life at this time? _____
Do you have a history of depression? **Yes** **No**
Prior counseling? **Yes** **No** If yes, what was/is the treatment plan? _____

Rate your pain level on a scale of 0-10, with 0= no pain and 10= worst possible pain: _____
Describe pain: _____ Location: _____ Duration: _____
If you are on Oxygen, what is your liter flow at rest: _____ With activity: _____ Sleeping: _____

_____
Patient Label or Name and DOB

Symptoms: Check any of the following symptoms you are currently experiencing: ☐ No symptoms at all

☐ Chest pain/discomfort ☐ Excessive thirst ☐ Heart palpitations ☐ Weight **gain/loss**: lbs.: _____
☐ Dizziness/lightheaded ☐ Cough on exertion ☐ Fatigue ☐ Difficulty concentrating
☐ Shortness of Breath ☐ Difficulty sleeping ☐ Loss of appetite ☐ Non-healing wounds/sores
☐ Leg pain while walking ☐ Recurring headaches ☐ Tremors/shakiness ☐ Recent vision changes
☐ Swelling- Feet or Hands ☐ Sexual problems ☐ Other: _____

Musculoskeletal Problems: Check all that apply.

☐ Fractures-current: _____ ☐ Trauma/Injuries: _____ ☐ Prosthetics: _____
☐ Knee/Hip problems: _____ ☐ Arthritis: _____ ☐ Assist device: _____
☐ Neck/Back problems: _____ ☐ Osteoporosis: _____ ☐ Other: _____

Fall Risk Screen: Circle the best answer.

1. Have you fallen more than once in the past year? **Yes No**
2. Have you experienced a stroke or other neurological problems that have affected your balance? **Yes No**
3. Do you feel unsteady when you are walking or climbing stairs? **Yes No**
4. Are you currently taking any medications that may affect your balance? **Yes No**

I take my medication as prescribed_____% of the time.

What is the highest grade you completed in school? _____

I learn best by: Check all that apply

☐ Reading ☐ Listening ☐ Demonstrating ☐ Audio/Visual ☐ Classroom ☐ Individual ☐ Computer

Have you attended Cardiac Rehab during or after 2010? **Yes No**

Patient Signature: _____ Date: _____

FOR STAFF USE ONLY

Readiness to learn: **Yes No** Barriers to Learning: _____

Physical Activity Level: _____ KX Modifier needed? **Yes No**

Current Weight: _____ Height: _____ Waist Circ: _____

☐ No Fall Risk at this time ☐ Fall prevention protocol implemented: _____

Completed By: _____ Time: _____ Date: _____

_____
Patient Label or Name and DOB