Name: ________________________________
Date Completed: _______________________

INSTRUCTIONS: This questionnaire will provide information needed to evaluate you for the Cardiac Rehabilitation Program. All the questions asked of you will help the rehabilitation staff understand how your condition has affected your life. This information is confidential and will be used to provide you the best of care. After you have completed and returned the questionnaire, the clinical staff will meet with you to discuss the program.
## DEMOGRAPHICS:

Name: ___________________________  Age: __________

Primary language: ___________  Height: ___  Weight: ___

Highest level of education completed:  
- [ ] No schooling beyond the 8th grade  
- [ ] Attended some high school  
- [ ] Completed high school  
- [ ] Attended college, trade school or other training requiring the completion of high school.  
- [ ] Attended post graduate training  
- [ ] Completed post graduate training

Current or most recent occupation: ___________________________

Status:  
- [ ] Full Time  
- [ ] Part time  
- [ ] Self-employed  
- [ ] Homemaker  
- [ ] Retired ___ years  
- [ ] Unemployed ___ years due to __________________________

Relationship Status:  
- [ ] Single  
- [ ] Separated  
- [ ] Married  
- [ ] Widowed  
- [ ] Domestic Partner:  
  - [ ] Female  
  - [ ] Male

With whom do you live: Name: ___________________________  Relationship: __________

## DOCTORS:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internist:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiologist:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ALLERGIES:  [ ] No Known Allergies

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>REACTION</th>
</tr>
</thead>
</table>

| | |
| | |
| | |
| | |
| | |
| | |
**MEDICATIONS:** List all medications you currently take including over the counter and vitamins

<table>
<thead>
<tr>
<th>Name of Medications</th>
<th>Dosage</th>
<th>How many times/day were you told to take the medicine?</th>
<th>Specify the time of day you take the medicine</th>
</tr>
</thead>
<tbody>
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<td>PM</td>
</tr>
</tbody>
</table>
### Coronal Risk Factors

#### Health History

How many close blood relatives (parent, brother, sister, or child) have had coronary heart disease BEFORE the age of 60?

Check if you have ever been told that you had any of the following, and specify the year diagnosed.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Year Diagnosed</th>
<th>treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>Sugar Diabetes</td>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>High Triglycerides</td>
<td></td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

What was your most recent cholesterol level? ____________  Unknown

Approximate date? __/__/__

What was your highest cholesterol level? ____________  Unknown

Approximate date: __/__/__

#### Social History

Did you ever smoke cigarettes?  Yes/No

If yes, please answer the following:

How many years did you or have you smoked? ____________ years

On the average, at your maximum, how many packs per day did you smoke?

<table>
<thead>
<tr>
<th>Packs per day</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than ½ pack</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1 pack per day</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

Have you stopped smoking entirely?  Yes/No

If yes, date stopped: __/__/__ (month/day/year)

If no, please answer the following:

On the average, how many packs per day do you presently smoke?

<table>
<thead>
<tr>
<th>Packs per day</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than ½ pack</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1 pack per day</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

Does anyone that lives with you smoke?  Yes/No

PRIOR to your recent cardiac illness, did you drink any kind of alcoholic beverages?  Yes/No

If yes, please answer the following:

How often?  daily 2-3 times / week weekly monthly

When you did drink, how many drinks did you have per day ____________

1 drink = 4 oz wine or one shot hard liquor or 12 oz beer

#### Nutrition

PRIOR to your recent cardiac illness:

How many servings of fruit or fruit juice did you eat per day? (i.e. one piece of fruit, or one cup raw fruit, ¼ cup canned fruit or fruit juice) ____________ servings

How many servings of vegetables or vegetable juice did you eat per day? (i.e. one cup raw or ½ cup cooked vegetables or vegetable juice) ____________ servings

How many servings of legumes (dried peas and beans like garbanzo, split peas lentils, etc) did you eat per week? (i.e. ½ cup cooked beans or one cup bean soup) ____________ servings
### Activity:

**Prior to your recent cardiac illness, did you do any of the following activities on a regular basis?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking for exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jogging or running</td>
<td></td>
<td></td>
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<tr>
<td>Hiking</td>
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<tr>
<td>Gardening or yard work</td>
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<td></td>
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<tr>
<td>Aerobics or aerobic dancing</td>
<td></td>
<td></td>
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<tr>
<td>Other dancing</td>
<td></td>
<td></td>
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<tr>
<td>Calisthenics or general exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Golf</td>
<td></td>
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<tr>
<td>Tennis</td>
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</tr>
<tr>
<td>Bowling</td>
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</tr>
<tr>
<td>Hiking</td>
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<tr>
<td>Gardening or yard work</td>
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<tr>
<td>Sexual intercourse</td>
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<tr>
<td>Other dancing</td>
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<tr>
<td>Car listhenics or general exercise</td>
<td></td>
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<tr>
<td>Housework</td>
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<tr>
<td>Golf</td>
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<tr>
<td>Tennis</td>
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<tr>
<td>Bowling</td>
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<td></td>
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<tr>
<td>Bicycle riding</td>
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<tr>
<td>Swimming or water exercises</td>
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<td></td>
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<tr>
<td>Horseback riding</td>
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<td></td>
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<tr>
<td>Handball, racquetball, or squash</td>
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<td></td>
</tr>
<tr>
<td>Housework</td>
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</tr>
</tbody>
</table>

If you have done any other exercises, sports, or physically active hobbies in the past two weeks other than the ones listed above, please list them: ____________________________

### Stress Assessment:

**Prior to your recent cardiac illness, did you perform stress reduction techniques or exercises? (i.e. breathing exercise, yoga, meditation, prayer)**

- Yes
- No

How often?

- Several times per day
- Almost every day
- Once or twice a week
- Rarely
- Never

What type of stress reduction?

- Progressive muscle relaxation
- Breathing exercise / visualization
- Meditation
- Prayer
- Other

In the 5 years prior to my recent cardiac illness, I have experienced stress (including tension, irritability, anxiety, or sleeping difficulties) as a result of conditions at work or home:

- Never
- Sometimes
- Often
- Always during the past one year
- Always during the past 5 years

### Cardiac History:

When was your heart disease first discovered? _________ year

- Unknown

Which of the following happened first?

- Angina / Chest Discomfort
- Abnormal Treadmill stress test or EKG
- Coronary Angiogram
- Heart Attack
- Other

Have you ever had anginal pain and / or chest discomfort?

- Yes
- No

If yes, approximately when did this begin: _____ / _____ / _____ (mo / day / yr)
**CARDIAC HISTORY: (Cont’d)**

Please check if you have ever had any of the following, and what hospital you were treated at for that problem.

**HEART ATTACK:**
- Never _______ times
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________

**CORONARY ANGIOGRAM**
- Never _______ times
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________

**CORONARY BALLOON ANGIOPLASTY, LASER or STENT PLACEMENT (PTCA):**
- Never _______ times
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________

**HEART SURGERY:**
- Never _______ times
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________

**HEART FAILURE:**
- Never _______ times
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________

**CARDIOMYOPATHY:**
- Never _______ times
  - Date: ___________ Hospital: ____________________
  - Date: ___________ Hospital: ____________________

For your most recent cardiac event how many days were you in the hospital? ____________

What was the date of your most recent EXERCISE STRESS TEST? Date: _____ / _____ / _____

What OTHER medical problems have you had?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### CURRENT SYMPTOMS

Currently, how often do you experience fatigue:
- [x] Never
- [ ] Even at rest
- [ ] During moderate to strenuous physical activity
- [ ] During ordinary daily activity

Currently, how often do you experience shortness of breath:
- [x] Never
- [ ] Even at rest
- [ ] During moderate to strenuous physical activity
- [ ] During ordinary daily activity

SINCE your recent surgery, angioplasty, or heart attack, have you had any pain or discomfort above your waist?
- [x] No
- [ ] N/A skip to next section
- [ ] Yes, complete the following

SINCE your recent surgery, angioplasty, or heart attack, have you had any pain or discomfort above your waist? *(Please answer even if you are entering the program for something other than the above.)*
- [ ] No
- [ ] Yes,
  - Where does your pain occur?
    - [x] Center of chest
    - [ ] Left side of chest
    - [ ] Neck or Jaw
    - [ ] Left arm
    - [ ] Other __________________________
  - Does most of your pain or discomfort occur during physical exertion and/or emotional distress?
    - [x] No
    - [ ] Yes
  - Does your pain or discomfort most often go away within 10 minutes if you rest or take nitroglycerin?
    - [x] No
    - [ ] Yes
  - If you recently had heart surgery, do you think this is incision pain?
    - [x] No
    - [ ] Yes

### FOR FEMALES

Has your natural menstruation stopped?
- [x] No
- [ ] Yes, at age: ____

Do you take estrogen now or have you ever taken estrogen?
- [x] Yes
- [ ] No

If yes, at what age did you start taking it?
- [ ] ____ years old

At what age did you stop taking it?
- [ ] ____ years old

Have you had any of the following surgeries?
- [x] Hysterectomy (removal of the uterus) ____ years old
- [ ] Removal of one ovary ____ years old
- [ ] Removal of both ovaries ____ years old

I have completed this questionnaire to the best of my knowledge

Patient Signature ______________________ Date ____________ Time ____________

For Clinical Use Only:

I have reviewed this questionnaire with the patient today:

Staff Printed Name __________________ Signature/Title __________________ Date ____________ Time ____________