



FORM H

THE PREVENTIVE & REHABILITATIVE CARDIAC CENTER
CARDIAC REHABILITATION PROGRAM
PATIENT HISTORY

Name: _____ Date: _____

Patient I.D. _____

CORONARY RISK FACTORS

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

of relatives _____

2) Have you ever been told that you had any of the following:	Year diagnosed	Has it been treated?
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sugar Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

3) a) What was your most recent cholesterol level? _____ Unknown
Approximate date? _____ / _____ / _____

b) What was your highest cholesterol level? _____ Unknown
Approximate date? _____ / _____ / _____

23) Have you been told by your physician that your cholesterol level is a problem? Yes No

4) Did you ever smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please answer the following:
a) How many years did you or have you smoked? _____ years
b) On the average, at your maximum, how many packs per day did you smoke?
<input type="checkbox"/> Less than 1/2 pack per day
<input type="checkbox"/> 1/2 to less than 1 pack per day
<input type="checkbox"/> 1 pack per day
<input type="checkbox"/> Greater than 1 pack per day

5) 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?

- Less than ½ pack per day
 ½ to less than 1 pack per day
 1 pack per day
 Greater than 1 pack per day

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

If yes, please answer the following:

a) How often?

<input type="checkbox"/> daily	<input type="checkbox"/> 2-3 times/week	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
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b) 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)

7) **PRIOR** to your recent cardiac illness:a) How many servings of **fruit or fruit juice** did you eat **per day**?
(i.e. one piece of fruit, or one cup raw fruit, ½ cup canned fruit or fruit juice)

_____ servings

b) 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

c) 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

8) **PRIOR** to your recent cardiac illness, did you do any of the following activities?

ACTIVITY	In a 14-day period, how many times on average have you been:	About how many minutes did you actually spend on each occasion?
Walking for exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Jogging or running? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hiking? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gardening or yard work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Aerobics or aerobic dancing? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other dancing? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Calisthenics or general exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Golf? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Tennis? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Bowling? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Bicycle riding? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Swimming or water exercises? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Horseback riding? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Handball, racquetball, or squash? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Sexual intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Housework? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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:

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

Yes No

a) How often?

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

b) What type of stress reduction?

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

10) 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

11) 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

12) Have you ever had anginal pain and/or chest discomfort? Yes No

If yes, approximately when did this begin: ____/____/____ (mo/day/yr)

13) Have you ever had a HEART ATTACK? Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____
Date: ____/____/____ Hospital: _____
Date: ____/____/____ Hospital: _____

Total # of heart attacks in your life _____

14) Have you ever had a CORONARY ANGIOGRAM? Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____
Date: ____/____/____ Hospital: _____
Date: ____/____/____ Hospital: _____

15) Have you ever had CORONARY BALLOON ANGIOPLASTY, LASER, OR STENT PLACEMENT (PTCA)? Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____
Date: ____/____/____ Hospital: _____
Total # of PTCA's in your life: _____

16) Have you ever had HEART SURGERY? Yes No

If yes, answer the following:
Date: ____/____/____ Hospital: _____ Type of surgery: _____
Date: ____/____/____ Hospital: _____ Type of surgery: _____
Date: ____/____/____ Hospital: _____ Type of surgery: _____

17) Have you ever had HEART FAILURE? Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____
Date: ____/____/____ Hospital: _____

18) Have you ever had CARDIOMYOPATHY? Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____

19) During your MOST RECENT cardiac event, were you hospitalized? Yes No

If yes, how many days did you spend in the hospital? _____ days
Date: ____/____/____ Hospital: _____

20) What was the date of your most recent EXERCISE STRESS TEST?

Date: ____/____/____

Where was it done? _____

21) What other medical problems have you had?

22) 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.) Yes No

If no, please skip to #23. If yes, answer the following:

- a) Where does your pain occur?
- Center of chest
 - Left side of chest
 - Neck or Jaw
 - Left arm
 - Other _____ (specify)
- b) Does most of your pain or discomfort occur during physical exertion and/or emotional distress? Yes No
- c) Does your pain or discomfort most often go away within 10 minutes if you rest or take nitroglycerin? Yes No
- d) If you recently had heart surgery, do you think this is incisional pain? Yes No

23) Currently, I experience fatigue:

- Never
- During moderate to strenuous physical activity
- During ordinary daily activity
- Even at rest

24) Currently, do you experience shortness of breath?

- Never
- During moderate to strenuous physical activity
- During ordinary daily activity
- Even at rest

25) If you are FEMALE, answer the following:

- a) Has your natural menstruation stopped? Yes No
If yes, at what age did it stop? _____ years old
- b) Do you take estrogen now or have you ever taken estrogen? Yes No
If yes, at what age did you start taking it? _____ years old
At what age did you stop taking it? _____ years old
- c) Have you had any of the following surgeries? Yes No
- (1) Hysterectomy (removal of the uterus) _____ years old
 - (2) Removal of one ovary _____ years old
 - (3) Removal of both ovaries _____ years old