Cardiac Rehabilitation Patient History Form

Social History
Age: _________ Circle one Male/Female Occupation:_________________
Are you currently working? □ Yes □ No
If no, are you planning on returning to this job? When? ________________________
Leisure/Fitness Activities: ________________________________________________
Tobacco: Packs per day: present ____ past ____ Year quit smoking ____________
Alcohol consumption : None □ Rare □ Social □ Drinks per day ________________

History of Present Illness:
What problem brings you here? ______________________________________________
When did this problem begin/date of the event? ________________________________
Describe the event: _________________________________________________________
Were you hospitalized? Where? __________________ How long? _________________
What diagnostic tests have you received? _____________________________________
Have you had surgery for this condition? If yes, please list type of surgery and dates. _

What treatments have you received for this condition? _________________________
Please list all the medications you are currently taking. __________________________
__________________________________________________________________________

Please list any allergies that you may have (medications, the environment, etc).
__________________________________________________________________________

Do you have pain? □ Yes □ No   If yes, where is your pain? ______________________
What relieves your pain? _____________________________________________________
What makes your pain worse? ________________________________________________

Please grade your pain level:
At rest

<table>
<thead>
<tr>
<th>Pain free</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Severe pain</th>
</tr>
</thead>
</table>

With activity

| Pain free | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-----------|---|---|---|---|---|---|---|---|---|---|----|-------------|

Cardiac History
Coronary artery disease risk factors; please check all that may apply to you.
□ High blood pressure □ Prior heart attack □ Angina □ High cholesterol □ Stress
□ Sedentary lifestyle □ Diabetes □ Body weight □ Currently smoking □ Family history
How many pillows do you sleep with? ____________ Do you experience shortness of
breath? □ Yes □ No   If yes, when does this occur? ______________________________

Please complete both sides of the form. Thank you.
Past Medical History
Please check and describe any of the following conditions that apply to you:

☐ Cancer ____________________  ☐ Kidney Disease ____________________
☐ Arthritis ____________________  ☐ Lung Disease ____________________
☐ Diabetes ____________________  ☐ Liver Disease ____________________
☐ HIV/AIDS ____________________  ☐ Deep Vein Thrombosis _____________
☐ Stroke ______________________  ☐ Seizure Disorder ________________
☐ Cellulitis/PVD ________________  ☐ Anxiety/Depression ______________

Please note any other medical conditions; previous injuries; other surgeries; hospitalizations; recurrent orthopedic problems, etc. ____________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Functional Status:
What activities at home are you having difficulty with? __________________________
____________________________________________________________________
What activities at work are you having difficulty with? __________________________
____________________________________________________________________
____________________________________________________________________

Please grade the following activities in terms of exertion: L=Light; M =Moderate; H=Heavy
Bathing and Dressing ________ Housework (cleaning, vacuuming, laundry) ________
Yard work (mowing, raking, gardening) ________ Shopping, carrying groceries ________
Working ________ Climbing stairs, walking uphill ________ Walking more than ½ hour ________

What do you hope to accomplish by participating in cardiac rehabilitation? __________
____________________________________________________________________

Patient signature: ____________________  Date: ____________________

For nurse or physical therapist use only: ______________________________________
____________________________________________________________________
____________________________________________________________________

History form reviewed with patient for accuracy. ☐
Signature ____________________  ID _____________  Date ____________________