Stony Brook Medicine

Cardiac Rehabilitation
Initial Assessment

Pt ID Label

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:

	0	1	2	3	4	5	6	7	8	9	10
At rest	**Pain free**										**Severe pain**
With activity	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.

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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 _____