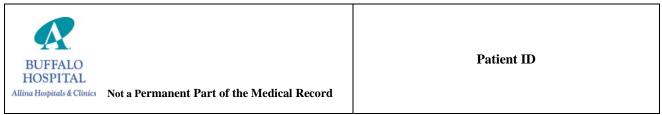
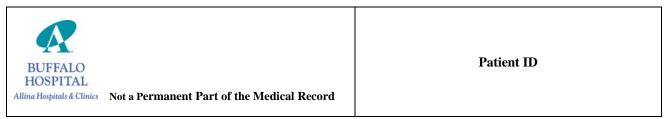
## Buffalo Outpatient Cardiac Rehabilitation Initial Assessment Patient Intake Form

Patient Name:   Primary care physician:   Cardiologist:   Cardiac History:   Heart attack, date:   Heart Failure   PTCA   Angina   Stenting   Valve Replacement   Surgery Date:		Clinic:		
Health History:				
<ul> <li>Diabetes</li> <li>High Blood Pressure</li> <li>High Cholesterol</li> <li>Heart murmur</li> <li>Stroke</li> <li>Depression</li> <li>Gastric Reflux (GERD)</li> <li>Fibromyalgia</li> <li>Rheumatoid Arthritis</li> <li>Osteoporosis</li> </ul>	] Lung Disease/C ] Asthma ] Tuberculosis ] Sleep Apnea ] Migraines ] Liver Disease	COPD	<ul> <li>Kidney Disease</li> <li>Epilepsy/Seizures</li> <li>Blackouts</li> <li>Thyroid Disease</li> <li>Latex Allergy</li> <li>Hepatitis</li> <li>Total Joint Replacement</li> <li>Type: When:</li> <li>Other surgeries:</li> </ul>	
Social History:				
Tobacco Use:       Never       Current: type       Former: Type       Quit Date         Alcohol Use:       Never       Yes, how often       Former: Type       Former: Type         Drug Use:       Never       Yes, type:       How often?       Former: Type       Former: Type         Have you received the flu shot within the last year?       No       Yes, when       Have you ever received the Pneumonia vaccination?       No       Yes, when         Do you have an Advance Directive?       No       Yes - Health Care Directive       Yes - Living Will         Yes - Durable Power of Attorney       Marrital Status:       Single       Married       Co-habitating       Separated       Widowed       Divorced				



Medication/Allergy History:					
Do you have a list of your medications with you currently?  Yes No					
If you have a list of your medicati	ons with you, p	lease	e provid	le the nurse with a cop	y. If not, please provide a
complete list of the medications y	ou are current	ly taki	ng at h	ome as well as any all	ergies you might have.
Do you carry a list of your medica	tions in your	purse	/wallet	t? 🗌 Yes 🗌 No	
Allergies/Sensitivities you might I herbs, foods, dye, latex, tape, etc.)	n <b>ave</b> (List drug	js,		tions you had (List hi hing difficulties, unkno	ves, nausea, vomiting, Severe wn, etc.)
				,	· · · · ·
Medication/Drug	Dose (how much you take)	(ho	<b>oute</b> w do take)	How Often (frequency & when do you take)	<b>Reason</b> (why are you taking this med?)
	you laitoy	jeu	lanoj		
Social History:					
Where do you currently live? □ ⊦	lome 🗌 Apa	rtmen	it 🗌 /	Assisted Living 🗌 Ot	her
Who do you live with?  Alone  Spouse  Family  Other					
What is your current occupation?					
Are you currently, or have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone					
important to you? Yes No					



Social History:					
Have you fallen in the past two months?					
Do you have difficulty walking or use any assistive devices (i.e. ca	ne, walker	, etc.)?			
□ No □ Yes, type:	□ No □ Yes, type:				
Pain Assessment:					
Are you currently experiencing any pain?  Yes No					
If yes, where is your pain located?	If yes, where is your pain located?				
What would you rate your pain on a scale from 0 to 10 (0=no pain,	10=worst p	ain you have	ever had)?		
What is your "goal number" on that scale or the number where you	are comfor	table?			
What methods do you currently use to relieve your pain?					
Risk Assessment:					
<b>Do you have any family history of heart problems?</b> No Yes	s, explain: <sub>-</sub>				
Do you currently exercise?					
If so, how many days per week? H	How long e	ach time?			
What type of exercise?					
Do you have any home exercise equipment?  No Yes If y	/es, what ki	ind			
What is your current stress level?  High Medium Low					
Any major life changes in the last month?  No Yes, explain:					
What techniques do you use to deal with stress?					
Patient Health Questionnaire:					
Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "" to indicate your answer)			Nearly Every Day		
Little interest or pleasure in doing things.	0	1	2	3	
Feeling down, depressed or hopeless.0123			3		
Trouble falling or staying asleep, or sleeping too much.     0     1     2     3					
Feeling tired or having little energy.0123				3	
Poor appetite or overeating.0123				3	
Feeling bad about yourself – or that you are a failure or have let yourself or your family down.012				3	
Trouble concentrating on things, such as reading the newspaper0123or watching television.				3	

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Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
	Not	Somewhat	Very	Extremely
	difficult	difficult	difficult	difficult
If you identified any of the above as problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (check a box)				
Risk Assessment:				
Are you Diabetic?				
If yes, when were you diagnosed?				
How do you manage your Diabetes? 🗌 Diet 🔲 Oral Meds 🗌	Insulin 🗌	Glucose Mon	itoring	
Have you been told you have high cholesterol?				
Do you consider yourself overweight?  Yes No				
Would you like to lose weight? 🗌 No 🛛 🗌 Yes, how much would	l you like to	o lose?		
Have you been told you have high blood pressure?  Yes No				
Learning Assessment:				
Do you have any barriers/concerns that delay or slow down your ability to learn?  Yes No				
If yes, check all that apply:				
🗌 Vision Loss 🔲 Speech/language 🔲 Mental/emotional 🔲 Reading 🔲 Hearing Loss				
🗌 Learning Disability 🔲 Culture/religious issues 🔲 Financial 🔲 Neurological				
How do you learn best? (check all that apply)				
Reading Listening Pictures Doing Video Other				
Goals:				
What goals do you have or what would you like to accomplish before completing cardiac rehab?				
Vitals (staff use only):				
Resting BP: (rt) (It) Exercise BP:		Post-Exercise	e BP:	
Resting HR: Exercise HR: Post-Exercise H	HR:	O2 Sa	ts:	
Ht: Wt: RR: Lu	ung Sound	s:		
Heart Sounds: Incision:	_Edema:_			
Comments:				

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