Buffalo Outpatient Cardiac Rehabilitation
Initial Assessment Patient Intake Form

Patient Name: _____ **Date Of Birth:** _____

Primary care physician: _____ **Clinic:** _____

Cardiologist: _____ **Clinic:** _____

Cardiac History:

- ☐ Heart attack, date: _____
- ☐ Heart Failure ☐ PTCA
- ☐ Angina ☐ Stenting
- ☐ Valve Replacement
  Surgery Date: _____
- ☐ Pacemaker - Date implanted: _____
- ☐ Implanted Defibrillator (ICD)
  Date implanted: _____
- ☐ Coronary Bypass Surgery (CABG)
  Surgery Date: _____

Health History:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart murmur
- ☐ Stroke
- ☐ Depression
- ☐ Gastric Reflux (GERD)
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Cancer/type: _____
  _____
- ☐ Lung Disease/COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Migraines
- ☐ Liver Disease
- ☐ Other: _____
  _____
- ☐ Kidney Disease
- ☐ Epilepsy/Seizures
- ☐ Blackouts
- ☐ Thyroid Disease
- ☐ Latex Allergy
- ☐ Hepatitis
- ☐ Total Joint Replacement
  Type: _____ When: _____
- ☐ Other surgeries: _____
  _____

Social History:

Tobacco Use: ☐ Never ☐ Current: type _____ ☐ Former: Type _____ Quit Date _____

Alcohol Use: ☐ Never ☐ Yes, how often _____

Drug Use: ☐ Never ☐ Yes, type: _____ How often? _____ ☐ 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

Marital Status: ☐ Single ☐ Married ☐ Co-habitating ☐ Separated ☐ Widowed ☐ Divorced

BUFFALO HOSPITAL
Allina Hospitals & Clinics

Not a Permanent Part of the Medical Record

Patient ID

Medication/Allergy History:

Do you have a list of your medications with you currently? ☐ Yes ☐ No

If you have a list of your medications with you, please provide the nurse with a copy. If not, please provide a complete list of the medications you are currently taking at home as well as any allergies you might have.

Do you carry a list of your medications in your purse/wallet? ☐ Yes ☐ No

Allergies/Sensitivities you might have (List drugs, herbs, foods, dye, latex, tape, etc.)	**Reactions you had** (List hives, nausea, vomiting, Severe breathing difficulties, unknown, etc.)

Medication/Drug	**Dose** (how much you take)	**Route** (how do you take)	**How Often** (frequency & when do you take)	**Reason** (why are you taking this med?)

Social History:

Where do you currently live? ☐ Home ☐ Apartment ☐ Assisted Living ☐ Other _____

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? ☐ No ☐ Yes

Do you have difficulty walking or use any assistive devices (i.e. cane, walker, etc.)?

☐ No ☐ Yes, type: _____

Pain Assessment:

Are you currently experiencing any pain? ☐ Yes ☐ No

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 pain you have ever had)? _____

What is your "goal number" on that scale or the number where you are comfortable? _____

What methods do you currently use to relieve your pain? _____

Risk Assessment:

Do you have any family history of heart problems? ☐ No ☐ Yes, explain: _____

Do you currently exercise? ☐ No ☐ Yes

If so, how many days per week? _____ How long each time? _____

What type of exercise? _____

Do you have any home exercise equipment? ☐ No ☐ Yes If yes, what kind _____

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)***	**Not At All**	**Several Days**	**More than half the days**	**Nearly Every Day**
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed or hopeless.	0	1	2	3
Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
Feeling tired or having little energy.	0	1	2	3
Poor appetite or overeating.	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3

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 difficult	**Somewhat difficult**	**Very difficult**	**Extremely 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? ☐ Yes ☐ No

If yes, when were you diagnosed? _____

How do you manage your Diabetes? ☐ Diet ☐ Oral Meds ☐ Insulin ☐ Glucose Monitoring

Have you been told you have high cholesterol? ☐ Yes ☐ No

Do you consider yourself overweight? ☐ Yes ☐ No

Would you like to lose weight? ☐ No ☐ Yes, how much would you like to 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)_____ **(lt)**_____ **Exercise BP:** _____ **Post-Exercise BP:** _____

Resting HR: _____ **Exercise HR:** _____ **Post-Exercise HR:** _____ **O2 Sats:** _____

Ht: _____ **Wt:** _____ **RR:** _____ **Lung Sounds:** _____

Heart Sounds: _____ **Incision:** _____ **Edema:**_____

Comments: _____