Do You Know Your Risk Factors for Coronary Artery Disease? **Name_____**

Cardiac Medical History (please check)	**Date(s)**
□ Myocardial Infarction (Heart Attack)	
□ Stent x	
□ CABG x (Coronary Artery Bypass Graft)	
□ Valve Repair / Replacement	
□ Pacemaker / AICD	
□ Congestive Heart Failure	
□ Arrhythmias (Irregular Heart Beat or Rhythm)	
□ Angina / Symptoms	
□ Other	

Uncontrollable Risk Factors:

Gender and Age: What is your age? _____ Male _____ Female _____

Family History: Do you have a family history of heart disease? Yes / No /Do not know

Prior Heart Event: Have you suffered a heart event in the past (prior to your recent event)? Yes / No

If yes, please describe: _____

Controllable Risk Factors:

High Blood Pressure: Are you currently taking medication for high blood pressure? Yes / No

High Cholesterol: Are you currently taking cholesterol medication? Yes/ No

Smoking/Tobacco Use: Are you a: Current smoker _____ Past smoker _____ Never a smoker _____

If Current or Past: Packs per day: _____ Years Smoked: _____ Quit Date: _____

Diabetes: Do you have Type I diabetes? Yes / No Do you have Type II diabetes? Yes / No

Do you have Pre-diabetes? Yes / No

Obesity: Height: _____ Weight: _____ Goal Weight: _____

Sedentary Lifestyle: What were you doing for exercise in the 2 weeks prior to your heart event?

Activity: _____ Mins/day: _____ Days/week____

What have you been doing for exercise since your heart event?

Activity: _____ Mins/day: _____ Days/week____

Are there any specific activities you want to be able to do again? _____

What are your barriers to exercise? _____

Patient Name:

Stress: What is currently causing you stress? _____

What do you do to relax/get rid of stress? _____

Sleep Apnea: Do you have Sleep Apnea? Yes / No If yes, do you use a **CPAP** or **Oral device**? Yes / No

Medications: Are you consistently taking all your medications as prescribed? Yes / No

If you answered "No," please explain: _____

Do you carry a list of your medications with you: Yes / No

Do you have a prescription for Nitroglycerin? Yes / No

If yes, do you carry your Nitroglycerin with you at all times? Yes / No

Do you have any allergies to medications? Yes / No

If yes, please list: _____

Do you drink caffeine? Yes / No What kind? Coffee_____ Soda_____Tea_____

If yes, how many cups per day? _____

Do you drink alcohol? Yes / No What kind? Beer_____ Wine_____ Hard Liquor_____

If yes, how many drinks per day or per week? _____

Do you have any orthopedic/musculoskeletal issues? Yes / No (If yes, please indicate)

□ Foot/Ankle L/R_____ □ Hips L/R _____

□ Knee L/R _____ □ Back _____

□ Shoulder L/R _____ □ Other_____

Do you currently use a cane or walker? Yes / No

Goals: What goals would you like to achieve while in the cardiac rehab program? (Pick up to 3)

◯ Begin a home exercise program ◯ Blood pressure control ◯ Diabetes management

◯ Improve my nutrition ◯ Stop smoking ◯ Return to previous activities

◯ Lose weight ◯ Symptom management ◯ Increase fitness level

◯ Improve cholesterol numbers ◯ Stress Management ◯ Other _____

Emergency Contact Person: _____ **Emergency Contact Phone #:** _____

Cardiologist: _____ **Primary Doctor:** _____

Other medical specialists you see: _____
