St. Luke's Rehabilitation Institute
INLAND NORTHWEST HEALTH SERVICES

Cardio/Pulmonary Rehab Program
Health Summary

www.st-lukes.org

NAME: _____ **DATE:** ___/___/_____ Age**:** _____ Sex ☐ M ☐ F

Primary Phone: (____) _____ ☐ Mobile ☐ Home ☐ Other_____

Alternative Phone: (____) _____ ☐ Mobile ☐ Home ☐ Other_____

Email Address: _____

Emergency Contact: _____ (____) _____ _____
Name Phone # Relationship

LANGUAGE_____ **ETHNICITY: (Mark box below)**

☐Black/African American ☐Asian/Pacific American ☐White American
☐Native American/Alaskan Native ☐Latina/Latino/Hispanic American ☐Other_____

TRAVEL RISK SCREENING: Have you or someone you are in contact with traveled out of the country in the last 21 days? ☐NO ☐YES/LOCATION_____.

If YES, Are you or the person you are in contact with experiencing any of the following symptoms:

☐Bleeding ☐Diarrhea ☐Vomiting/Stomach Pain
☐Joint/Muscle pain ☐Headache ☐Rash
☐Respiratory Symptoms ☐Temp over 100.4F ☐Conjunctivitis/Pink eye

For Staff only: ☐Referred to PCP_____

REASON FOR THERAPY ☐Cardiac Rehab_____ ☐Pulmonary Rehab_____

CARDIOLOGIST: _____ **PULMONOLOGIST:**_____

WHAT ARE YOUR THERAPY GOALS?_____

HAVE YOU ATTENDED REHAB THERAPY BEFORE? ☐NO ☐YES/LOCATION_____

WILL YOU HAVE FAMILY/FRIEND SUPPORT WHILE ATTENDING REHAB? ☐NO ☐YES

MEDICAL HISTORY: (Mark a box if you have had any of these conditions and explain below)

☐ Anemia
☐ Anxiety/Depression
☐ Asthma
☐ Chronic Bronchitis
☐ Congestive Heart Failure
☐ Diabetes Mellitus
☐ Emphysema
☐Ocular Blood Vessel changes
☐ Hearing loss
☐Heart Attack
☐ Heart Disease
☐Heart Transplant
☐ Irregular Heart Rhythm
☐ Hepatitis
☐ HIV / AIDS
☐ Hypertension (High Blood Pressure)
☐ Kidney Problems
☐ Mental illness
☐ Nerve Damage to Feet
☐ Non-healing wounds
☐Pacemaker/☐Defibrillator
☐ Pulmonary Disease/COPD
☐ Seizures
☐ Stroke
☐ Substance Abuse
☐ Tuberculosis

☐ Other (Please List) _____ Explain: _____

DIABETIC EVALUATION: (For Diabetics Only) Type 1☐ or Type 2☐ Date of onset ___/___/_____
Managing Physician :_____ Fasting Blood Sugar_____ HbA1C_____
Ideal blood sugar range:_____ Do you know the signs of hypo/hyperglycemia ☐YES ☐ NO
How frequently do you check your blood sugar?_____

ADDRESSOGRAPH

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SURGICAL HISTORY:

☐Angioplasty or Stent: ☐Yes ☐No Date of Surgery: ___/___/_____
☐Heart Bypass Surgery☐Yes ☐No Date of Surgery: ___/___/_____
☐Valve Repair or Replacement ☐Yes ☐No Date of Surgery: ___/___/_____
☐ Other (Please List) _____ Explain: _____

REVIEW OF SYSTEMS: (Please check all CURRENT symptoms)

Cardio: ☐Chest pain ☐Palpitations ☐Leg/foot swelling
Respiratory: ☐Coughing ☐Increased Mucus production
General: ☐Chills ☐Fatigue ☐Fevers ☐Unintentional Weight Loss
ENT: ☐Hearing loss ☐Congestion ☐Sore Throat
Eyes: ☐Blurred Vision ☐Eye pain ☐Double vision ☐Loss of vision ☐Light sensitivity
Urinary: ☐Blood in Urine ☐Urinary incontinence ☐Urinary retention
Neuro: ☐Dizziness ☐Tremors ☐Numbness ☐Seizures ☐Loss of balance
Gastrointestinal: ☐Heartburn ☐Nausea/Vomiting ☐Abdominal Pain ☐Blood in stool
Hematologic / Lymphatic: ☐Bleeding Problems ☐Blood clots ☐Blood transfusions ☐Bruising

SOCIAL HISTORY:

Tobacco/Nicotine Use:
☐Currently using ☐Has used in the past ☐Passive usage ☐Never used ☐Exposure to 2nd hand smoke

Which of the following are you using or have you used:☐**E-Cigarettes** ☐ **Smoking Tobacco** ☐**Smokeless Tobacco**
How many years have you used Tobacco/Nicotine: _____Quit Date: ___/___/___
What technique helped you quit?_____
_____
If not, are you interested in setting a quit date:
☐Yes ☐No

Alcohol use: ☐Yes ☐No Times per week_____
Drug Use: ☐Yes ☐No Times per week_____
Caffeine Use: ☐Yes ☐No Amount per day_____

Exercise: Type of activity_____
☐ 1 time per day ☐ Few times per week ☐ Few times per month ☐ Never

Current Quality of Life/Health Status: ☐Excellent ☐Good ☐Fair ☐Poor

Readiness to change your current lifestyle behaviors:
☐Resist Change ☐Thinking about change ☐Preparing to Change ☐Change ☐Already made changes

Do you have ☐transportation, ☐housing, or ☐financial concerns? ☐NO
☐YES_____

Are you concerned about your safety or violence at home? ☐NO
☐YES_____

MEDICATION LIST: (List below or bring a printed copy of complete list of medications)

Medication/Injection	Dosage	Prescribing Physician	Phone Number
			(____)
			(____)
			(____)
			(____)
			(____)

We have provided the following documents for your review:*(Copies are available upon your request)*
☐Patient Rights and Responsibilities ☐Consent to Treat

_____ _____ __/__/___
Signature of Patient or Legal Guardian Relationship to patient Date

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