

Patient History (Form H)

Name: _____ Date: _____

 Patient ID _____

CORONARY RISK FACTORS

1) How many close blood relatives (parent, brother, sister, or child) have had coronary heart disease BEFORE the age of 60?

of relatives _____

2) Have you ever been told that you had any of the following:	Year diagnosed	Has it been treated?
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sugar Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

3) a) What was your most recent cholesterol level? _____ Unknown
 Approximate date? _____ / _____ / _____

b) What was your highest cholesterol level? _____ Unknown
 Approximate date? _____ / _____ / _____

c) Have you been told by your physician that your cholesterol level is a problem? Yes No

4) Did you **ever** smoke cigarettes? Yes No

If yes, please answer the following:

a) How many years did you or have you smoked? _____ years

b) On the average, at your maximum, how many packs per day did you smoke?

Less than ½ pack per day
 ½ to less than 1 pack per day
 1 pack per day
 Greater than 1 pack per day

5) Have you stopped smoking entirely? Yes No

If yes, date stopped: _____ / _____ / _____ (month/day/year)

If no, please answer the following:

On the average, how many packs per day do you presently smoke?

- Less than ½ pack per day
- ½ to less than 1 pack per day
- 1 pack per day
- Greater than 1 pack per day

6) Do you drink any kind of alcoholic beverages? Yes No

If yes, please answer the following:

a) How often?

<input type="checkbox"/> daily	<input type="checkbox"/> 2-3 times/week	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
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b) When you do drink, how many drinks did you have per day? _____

(1 drink = 4 oz wine or one shot hard liquor or 12 oz beer)

7) Please answer:

a) How many servings of fruit or fruit juice do you eat per day?
 (i.e., one piece of fruit, or one cup raw fruit, ½ cup canned fruit or fruit juice)

_____ servings

b) How many servings of vegetables or vegetable juice do you eat per day?
 (i.e., one cup raw or ½ cup cooked vegetables or vegetable juice)

_____ servings

c) How many servings of legumes (dried peas and beans like garbanzo, split peas lentils, etc) do you eat per week?
 (i.e., ½ cup cooked beans or one cup bean soup)

_____ servings

8) Do you do any of the following activities?

ACTIVITY		In a 14-day period, how many times on average have you been:	About how many minutes did you actually spend on each occasion?
Walking for exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Jogging or running?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Hiking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Gardening or yard work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Aerobics or aerobic dancing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other dancing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Calisthenics or general exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Golf?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Tennis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Bowling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Bicycle riding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Swimming or water exercises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Horseback riding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Handball, racquetball, or squash?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sexual intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Housework?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

If you have done any other exercises, sports, or physically active hobbies in the past two weeks other than the ones listed above, please list them:

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9) Do you perform stress reduction techniques or exercises?
 (i.e., breathing exercise, yoga, meditation, prayer) Yes No

- a) How often?
- Several times per day
 - Almost every day
 - Once or twice a week
 - Rarely
 - Never
- b) What type of stress reduction?
- Progressive muscle relaxation
 - Breathing exercise/visualization
 - Meditation
 - Prayer
 - Other

10) Please answer as appropriate, I have experienced stress (including tension, irritability, anxiety or sleeping difficulties) as a result of conditions at work or home:

- Never
- Sometimes
- Often
- Always during the past one year
- Always during the past 5 years

11) Have you ever been told you have heart disease? Yes No Unknown
 If yes, when? _____ year

Which of the following happened first? Answer only if applicable.

- Angina/Chest Discomfort
- Abnormal Treadmill stress test or EKG
- Coronary Angiogram
- Heart Attack
- Other

12) Have you ever had anginal pain and/or chest discomfort? Yes No

If yes, approximately when did this begin: ____/____/____ (month/day/year)

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13) Have you ever had a heart attack?

Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____

Date: ____/____/____ Hospital: _____

Date: ____/____/____ Hospital: _____

Total # of heart attacks in your life _____

14) Have you ever had a coronary angiogram?

Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____

Date: ____/____/____ Hospital: _____

Date: ____/____/____ Hospital: _____

15) Have you ever had coronary balloon angioplasty, laser or stent placement (PTCA)?

Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____

Date: ____/____/____ Hospital: _____

Total # of PTCA's in your life: _____

16) Have you ever had heart surgery?

Yes No

If yes, answer the following:

Date: ____/____/____ Hospital: _____ Type of surgery: _____

Date: ____/____/____ Hospital: _____ Type of surgery: _____

Date: ____/____/____ Hospital: _____ Type of surgery: _____

Patient ID _____

17) Have you ever had heart failure?

Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____

Date: ____/____/____ Hospital: _____

18) Have you ever had cardiomyopathy?

Yes No

If yes, answer the following: Date: ____/____/____ Hospital: _____

19) If you have experienced a cardiac event, were you hospitalized?

Yes No

If yes, how many days did you spend in the hospital? _____ days

Date: ____/____/____ Hospital: _____

20) What was the date of your most recent exercise stress test?

(Answer only if applicable)

Date: ____/____/____

Where was it done? _____

21) What other medical problems have you had?

22) *Answer only if appropriate. Since your recent surgery, angioplasty or heart attack, have you had any pain or discomfort above your waist? (Please answer even if you are entering the program for something other than the above.)*

Yes No

If no, please skip to #23. If yes, answer the following:

- a) Where does your pain occur?
- Center of chest
 - Left side of chest
 - Neck or Jaw
 - Left arm
 - Other _____ (specify)
- b) Does most of your pain or discomfort occur during physical exertion and/or emotional distress? Yes No
- c) Does your pain or discomfort most often go away within 10 minutes if you rest or take nitroglycerin? Yes No
- d) If you recently had heart surgery, do you think this is incisional pain? Yes No

23) Currently, I experience fatigue:

- Never
- During moderate to strenuous physical activity
- During ordinary daily activity
- Even at rest

24) Currently, do you experience shortness of breath?

- Never
- During moderate to strenuous physical activity
- During ordinary daily activity
- Even at rest

25) Please answer the following:

- a) Has your natural menstruation stopped? Yes No
 If yes, at what age did it stop? _____ years old
- b) Do you take estrogen now or have you ever taken estrogen? Yes No
 If yes, at what age did you start taking it? _____ years old
 At what age did you stop taking it? _____ years old
- c) Have you had any of the following surgeries? Yes No
- (1) Hysterectomy (removal of the uterus) _____ years old
 - (2) Removal of one ovary _____ years old
 - (3) Removal of both ovaries _____ years old