PATIENT IDENTIFICATION LABEL	Penn Medicine Chester County Hospital **Cardiac Rehabilitation Participant Health History**

NAME: _____ DATE OF BIRTH: _____

Allergies/Reactions: _____

_____

Latex Allergy? □ Yes □ No

Primary Care Physician: _____ Phone: _____Fax:_____

Cardiologist: _____ Phone: _____Fax:_____

Endocrinologist: _____ Phone: _____ Fax: _____

Other: _____ Phone: _____ Fax: _____

Who lives at home with you? _____

Do you feel safe? □ Y □ N

Family is: □ Supportive □ Non-supportive

Your occupation now or at time of retirement: _____ Year retired: _____

Have you returned to work? □ No □ Yes If yes, when? _____

What hours? □ Full time □ Part time □ Other _____ Are you in the same position? □ Y □ N

Do you have an advanced directive? □ Yes □ No (If yes, please bring to the interview)

Factors that affect your care or treatment

Do you have any cultural or religious practice/ beliefs that may affect your care or treatment?

No □ Yes □ Describe _____

Do you have any factors which affect learning? No □ Yes □ Describe_____

Do you read / write English? Yes □ No □ If no, what language? _____

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Exercise:

Rank how often you exercise: □ Daily □ 6x week □ 3x week □ less than 2x/week □ Never

Do you have exercise equipment at home? □ Y □ N Type: _____

Describe your exercise program **before** your medical event: _____

Describe your exercise program **after** your medical event: _____

Cardiac Risk Factors

What do you think led to your heart disease? Check areas that apply.

Not Modifiable

□ Age
□ Gender
□ Family History

Modifiable

□ Smoking/Tobacco Use
Do you use tobacco now? Yes □ No □ Quit Date _____
Type of Tobacco Use
□ Cigarettes □ Cigars □ Chewing tobacco □ E-cigarettes
How much per day?_____
How many years? _____

□ High Blood Pressure
□ High Cholesterol / Triglycerides
□ Lack of physical activity
□ Diabetes □ Type I □ Type II
□ Stress (if yes, see below)
□ Overweight

Stress Level: □ Low □ Moderate □ High

Stress is related to: □ Work □ Family □ Marriage □ Finances □ Illness □ Other _____

Social:
Sex Life: Are you interested in additional information? □ Yes □ No

Alcohol:
Do you drink alcohol? □ No □ Yes How many drinks per day _____ or per week _____
What type of alcohol do you drink (circle all that apply)? Wine Beer Liquor
Do you have a history of alcohol abuse? □ Yes □ No

Recreational Drugs:
Do you use any recreational drugs? Yes No
What type of drugs? _____ How often? _____

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Medical History

Cardiac History	**Other Medical History**	
☐ Abnormal heart rhythm	☐ Anemia	☐ Peripheral vascular disease
☐ Cardiac Catheterization	☐ Arthritis	☐ Phlebitis
☐ Cardiomyopathy/enlarged heart	☐ Asthma	☐ Prostate problems
☐ Chest discomfort/angina	☐ Autoimmune disease	☐ Pulmonary Fibrosis
☐ Coronary angioplasty/balloon	☐ Bleeding problems	☐ Seizures/epilepsy
☐ Coronary bypass surgery	☐ Bursitis/Tendonitis	☐ Sinus problems
☐ Coronary stent placement	☐ Colitis, ileitis, or IBS	☐ Stomach ulcers
☐ Defibrillator (ICD)	☐ Diabetes Type I or II (circle)	☐ Thyroid problems
☐ Heart Attack	☐ Diverticulitis	☐ Tuberculosis
☐ Heart Failure	☐ Emphysema/COPD	☐ Other
☐ Heart Murmur	☐ Fatigue/Chronic	**Surgeries (Please list)**
☐ Heart Transplant	☐ Frequent urination	
☐ Heart Valve problems/surgery	☐ Gallbladder disease	
☐ High Cholesterol/Triglycerides	☐ Headaches/Migraines	
☐ Pacemaker	☐ Hepatitis	
☐ Rheumatic fever	☐ Hernia – abdominal, inguinal	
☐ Ventricular Assist Device (VAD)	☐ Hiatal hernia/reflux	
Psychosocial History	☐ High blood pressure	
☐ Anxiety	☐ HIV	
☐ History of Depression	☐ Kidney problems	
☐ Sleep Disturbance	☐ Leg cramps	
☐ Type A personality	☐ Lightheadedness/dizziness	
☐ Other (please explain)	☐ Liver disease	
	☐ Osteoporosis	

**********FOR STAFF USE ONLY – PLEASE DO NOT WRITE BELOW**********

Comments

_____

_____

Acknowledged by _____ Date _____Time _____