

**Cardiac Rehabilitation Patient History Form**

**Social History**

Age: \_\_\_\_\_ Circle one Male/Female Occupation: \_\_\_\_\_

Are you currently working?  Yes  No

If no, are you planning on returning to this job? When? \_\_\_\_\_

Leisure/Fitness Activities: \_\_\_\_\_

Tobacco: Packs per day: present \_\_\_\_ past \_\_\_\_ Year quit smoking \_\_\_\_\_

Alcohol consumption : None  Rare  Social  Drinks per day \_\_\_\_\_

**History of Present Illness:**

What problem brings you here? \_\_\_\_\_

When did this problem begin/date of the event? \_\_\_\_\_

Describe the event: \_\_\_\_\_

Were you hospitalized? Where? \_\_\_\_\_ How long? \_\_\_\_\_

What diagnostic tests have you received? \_\_\_\_\_

Have you had surgery for this condition? If yes, please list type of surgery and dates. \_

What treatments have you received for this condition? \_\_\_\_\_

Please list all the medications you are currently taking. \_\_\_\_\_

Please list any allergies that you may have (medications, the environment, etc).

Do you have pain?  Yes  No If yes, where is your pain? \_\_\_\_\_

What relieves your pain? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Please grade your pain level:

At rest	0	1	2	3	4	5	6	7	8	9	10
	Pain free										Severe pain
With activity	0	1	2	3	4	5	6	7	8	9	10

**Cardiac History**

Coronary artery disease risk factors; please check all that may apply to you.

- High blood pressure  Prior heart attack  Angina  High cholesterol  Stress
- Sedentary lifestyle  Diabetes  Body weight  Currently smoking  Family history

How many pillows do you sleep with? \_\_\_\_\_ Do you experience shortness of breath?  Yes  No If yes, when does this occur? \_\_\_\_\_

**Past Medical History**

Please check and describe any of the following conditions that apply to you:

- |   |   |
|---|---|
| <input type="checkbox"/> Cancer _____         | <input type="checkbox"/> Kidney Disease _____       |
| <input type="checkbox"/> Arthritis _____      | <input type="checkbox"/> Lung Disease _____         |
| <input type="checkbox"/> Diabetes _____       | <input type="checkbox"/> Liver Disease _____        |
| <input type="checkbox"/> HIV/AIDS _____       | <input type="checkbox"/> Deep Vein Thrombosis _____ |
| <input type="checkbox"/> Stroke _____         | <input type="checkbox"/> Seizure Disorder _____     |
| <input type="checkbox"/> Cellulitis/PVD _____ | <input type="checkbox"/> Anxiety/Depression _____   |

Please note any other medical conditions; previous injuries; other surgeries; hospitalizations; recurrent orthopedic problems, etc. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Functional Status:**

What activities at home are you having difficulty with? \_\_\_\_\_

What activities at work are you having difficulty with? \_\_\_\_\_

Please grade the following activities in terms of exertion: **L**=Light; **M** =Moderate; **H**=Heavy  
Bathing and Dressing \_\_\_\_\_ Housework (cleaning, vacuuming, laundry) \_\_\_\_\_  
Yard work (mowing, raking, gardening) \_\_\_\_\_ Shopping, carrying groceries \_\_\_\_\_  
Working \_\_\_\_\_ Climbing stairs, walking uphill \_\_\_\_\_ Walking more than ½ hour \_\_\_\_\_

What do you hope to accomplish by participating in cardiac rehabilitation? \_\_\_\_\_

\_\_\_\_\_

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For nurse or physical therapist use only: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

History form reviewed with patient for accuracy.

Signature \_\_\_\_\_ ID \_\_\_\_\_ Date \_\_\_\_\_