Hamilton Medical Center
Cardiac Rehabilitation

706-272-6574
www.hamiltonhealth.com/cardiacrehab

BRADLEY WELLNESS CENTER
CARDIAC HEALTH AND REHABILITATION

PARTICIPANT HEALTH HISTORY/ EVALUATION

{PLEASE COMPLETE AND BRING WITH YOU ON YOUR FIRST APPOINTMENT!}

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ **Alternate Phone:**_____

Who else lives at home with you? _____

Marital Status: married / partnered divorced widowed separated single

Birthdate: _____ **AGE:** _____ **SSN:** _____

Occupation / Company:_____

Work phone: _____

Emergency Contact: _____ Relationship:_____

Phone number during day: _____

Date of most recent heart procedure/event: _____

Who is your heart doctor? _____

Who is your family doctor? _____

When is your next appointment with your heart doctor? (Date)_____

MEDICAL HISTORY

Height: _____ **Weight:** _____

Have you had a recent weight change? ☐ Yes ☐ No

Goal for Weight Control: ☐ Lose weight ☐ Gain Weight ☐ Maintain Weight

What would you consider to be your goal weight: _____ lbs.

Nutrition **(Check all that apply)**

Current Diet: ☐ Regular (No restrictions) ☐ Low fat/Low cholesterol ☐ Low sodium

☐ Vegan ☐ Diabetic diet (ADA) ☐ Lactose free ☐ Gluten free ☐ Renal

Alcohol Use: ☐ None ☐ Daily ☐ Weekly ☐ Monthly ☐ Special Occasions

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Please check if you have or have ever been told by a doctor that you have any of the following conditions:

Cardiovascular	**Vision/Hearing**
☐ Heart attack	☐ Vision problems
☐ Stent placement	☐ Hearing problems
☐ Congenital heart defect	**Other Health Issues**
☐ Congestive heart failure	☐ Anemia (low blood iron levels)
☐ Fluid retention	☐ Lightheadedness / dizziness
☐ ICD (heart defibrillator)	☐ Fainting
☐ Heart valve problems / surgery	☐ Headaches
☐ Pacemaker	☐ Seizures / epilepsy
☐ Coronary artery bypass surgery	☐ Bleeding problems
☐ Chest incision problems	☐ Kidney problems
☐ Coronary angiogram	☐ Autoimmune/Chronic infection
☐ Coronary angioplasty (balloon)	☐ Edema
☐ Chest discomfort/angina	☐ High cholesterol
Level of activity that causes chest pain:	☐ Diabetes (if checked, answer below)
☐ Mild ☐ Moderate ☐ Strenuous	**Diabetes Type:** ☐ Type 1 ☐ Type 2
☐ Abnormal heart rhythm	**Diabetes Care: (check all that apply)**
☐ Peripheral Artery Disease (PAD)	☐ Check blood sugars daily
☐ High blood pressure	☐ Follow carb counting diet
High blood pressure: Controlled/Uncontrolled	☐ Other:
☐ Low blood pressure	**Recent blood sugar:**
☐ Stroke	**Fasting blood sugar:**
☐ Family history of heart disease/stroke	**Diabetes symptoms: (check all that apply)**
Musculoskeletal	☐ Weak ☐ Dizzy ☐ Shaking
☐ Back problems (muscular/joint)	☐ Sweating ☐ Confusion
☐ Shoulder discomfort (muscular/joint)	☐ Anxious ☐ Fast heart beat
☐ Knee discomfort (muscular/joint)	**Diabetic Goals: (check all that apply)**
☐ Neck discomfort (muscular/joint)	☐ Be compliant with diabetic medications
☐ Arthritis	☐ Monitor blood glucose levels regularly
☐ Disc problems / disease	☐ Start/maintain diabetic diet
☐ Bone fracture	**Psychosocial**
☐ Osteoporosis	☐ Depression
Pulmonary	☐ High stress (if checked, answer below)
☐ COPD	**Stressors: (check all that apply)**
☐ Pulmonary embolism	☐ Health
☐ Pulmonary Fibrosis	☐ Family
☐ Shortness of breath	☐ Finances
☐ Asthma	☐ Other:
☐ Cystic Fibrosis	Do you cope well with stressors in your life?
☐ Bronchitis	☐ Yes ☐ No

List any other health issues that were not mentioned above: _____

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Tobacco Use

Do you smoke? ☐ Yes ☐ No **Have you ever smoked?** ☐ Yes ☐ No
Type of tobacco product: ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Smokeless
How many years? _____
Do you desire to quit smoking? ☐ Yes ☐ No

Fall Risk Assessment

☐ Not at risk ☐ Dizziness ☐ Gait disturbance ☐ Visual impairment ☐ Balance disturbance
☐ Fall history within 3 months ☐ Medication side effect ☐ Needs assistance walking (crutches/cane/walker)

Pain Assessment :

Do you experience chronic pain? ☐ Yes ☐ No
If you answered Yes, please rate your pain level from 0 to 10 (0 having no pain, 10 extreme pain)
0 1 2 3 4 5 6 7 8 9 10

Location of pain_____ **What side of the body is the pain?** _____

Pain description: ☐ Aching ☐ Sharp ☐ Burning ☐ Tender ☐ Tingling
☐ Other:_____

What are you currently doing to help with the pain? (Check all that apply)
☐ Medication ☐ Heat applied ☐ Cold applied ☐ Compression wrap ☐ Topical cream
☐ Other:_____

Home Exercise

Are you currently exercising? ☐ Yes ☐ No

What type of exercise? (Check all that apply)
☐ Walking ☐ Biking ☐ Strength training ☐ Yard/housework ☐ None ☐ Other:_____

How much time do you take to exercise?
☐ 10-20 min/day ☐ 20-30 min/day ☐ >30 min/day ☐ None

How often do you exercise a week? ☐ 2-3 x wk ☐ 3-5 x wk ☐ >5 x wk ☐ None

Personal Goals

(Check all the goals that you would like to achieve in each category)

Exercise: ☐ Cardio 3-5 days/wk for >30 mins ☐ Strength training 2-3 days/wk

Nutrition: ☐ Achieve/Maintain goal range cholesterol levels ☐ Understanding label reading
☐ Decrease fat/cholesterol intake ☐ Increase fiber ☐ Decrease salt intake
☐ Decrease alcohol use ☐ Decrease sugar intake ☐ Increase water intake

Emotional: ☐ Maximize coping skills ☐ Achieve symptom resolution
☐ Improve self-confidence ☐ Take medications as prescribed ☐ Have a positive support system

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MEDICATIONS

Please list ALL medications and vitamins/supplements that you are taking.
You are welcome to bring a printed copy.

MEDICATION	DOSAGE/ROUTE	FREQUENCY	THIS MED IS FOR

Do you have any difficulty taking your medications? _____
Do you know what all of your medications do? _____

Allergies:

☐ **Medicines (list):** _____
☐ **Other:** _____

ADVANCE DIRECTIVES

- **Do you have a current Advanced Directive or a Living Will ?** ***Yes*** ***No***
- **If Yes, is it on file at Hamilton Medical Center?** ***Yes*** ***No***
- **If not, would you like to receive information on Advance Directives?** ***Yes*** ***No***

Thank you for taking time to complete this information. It will help us when evaluating your needs for cardiac rehabilitation. We want to make sure you receive the best care possible!

DO NOT SIGN HERE. STAFF USE ONLY:

I confirm that I have gone over all of the information in this packet with the patient.

STAFF SIGNATURE: _____ DATE: _____