

**Mission Hospital**  
**CARDIOPULMONARY REHABILITATION CENTER**

# About You

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please answer the following questions. There may be more than one answer.**

### NATURE OF HEART DISEASE

- Coronary Heart Disease     Occurs all of a sudden                       May be reversible  
    Is progressive     Is cured by angioplasty (balloon), bypass or stent

All of the following are risk factors for heart disease. Identify **YOUR RISK FACTORS**

- |   |  |
|---|--|
| <input type="checkbox"/> Blood fat levels (lipids/cholesterol)  | <input type="checkbox"/> Sleep Apnea           |
| <input type="checkbox"/> Hypertension (High blood pressure)   | <input type="checkbox"/> High fat diet         |
| <input type="checkbox"/> Overweight   | <input type="checkbox"/> Smoking               |
| <input type="checkbox"/> Stress and how you cope  | <input type="checkbox"/> Gender (Male)         |
| <input type="checkbox"/> Type-A personality (intense, driven, find it hard to relax, inappropriate anger/hostility, hold in emotions) | <input type="checkbox"/> Family history        |
| <input type="checkbox"/> Sedentary (inactive) lifestyle   | <input type="checkbox"/> Diabetes/Pre-Diabetes |

**What exercise were you doing prior to your cardiac event?**

Type \_\_\_\_\_ Minutes \_\_\_\_\_ Times per week \_\_\_\_\_

**Changing some of your behaviors such as diet, exercise, or smoking can help prevent future cardiac event or procedures.**     TRUE                       FALSE

### SIGNS & SYMPTOMS/MEDICATIONS

**All of the following can be symptoms of angina or associated with angina. Which ones have YOU experienced?**

- |  |  |                                   |
|--|--|-----------------------------------|
| <input type="checkbox"/> Chest Discomfort    | <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Fatigue  |
| <input type="checkbox"/> Shoulder Discomfort | <input type="checkbox"/> Abdomen Discomfort  | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Arm/Arms Discomfort | <input type="checkbox"/> Back Discomfort     | <input type="checkbox"/> Nausea   |
| <input type="checkbox"/> Neck Discomfort     | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Anxiety  |

**What do you do if symptoms of angina should occur?**

- Stop any activity in which I am engaged and sit down for 5 minutes of rest
- Sit or lay down, take nitroglycerin (tablet or spray) every 3-5 minutes up to a total of no greater than 3 times. If angina persists, call the paramedics (911). If angina is relieved, call my physician and inform of this incident.
- Continue activity and try to work through it
- If angina persists, drive myself to the hospital

**Check off the statements concerning medications that are TRUE:**

- If I forget to take my medication, I should increase the amount taken with the next dose
- I should not stop or change the dose of medications without consulting my physician(s)
- I should carry written information stating each medication I take, the dose, and how often I take it each day.

**PSYCH/SOCIAL/SPIRITUAL**

- It is important to learn to:  Appropriately assess priorities  
 Utilize activities that promote relaxation  
 Approach my work and lifestyle very intensely

Over the past 2 weeks, have you been bothered by any of the following things?

- Little or no interest or pleasure in doing things  
 Feeling down, depressed or hopeless  
 None of the above

**EDUCATION**

Please check off lifestyle changes that you have made

- |  |   |
|--|---|
| <input type="checkbox"/> Stopped smoking                                   | <input type="checkbox"/> Lost weight  |
| <input type="checkbox"/> Learned relaxation techniques                     | <input type="checkbox"/> Joined a support group   |
| <input type="checkbox"/> Decreased food portions or total calories in diet | <input type="checkbox"/> Made a new commitment to a healthy lifestyle change                  |
| <input type="checkbox"/> Decreased saturated fats in diet                  | <input type="checkbox"/> Obtained/read literature/books on<br>how to decrease my risk factors |
| <input type="checkbox"/> Started exercising regularly                      | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Started/improved diabetes management              |   |

Would you like to schedule a diet consult?  Yes  No

**HEART ATTACK**

It is very common that a person will deny that he/she is actually having a heart attack.  True  False

After a heart attack, a scar forms in the heart where the heart muscle damage occurred. This process takes 4-6 weeks.

True  False

**HEART SURGERY/CARDIAC INTERVENTIONAL PROCEDURES**

You can ignore angina-type symptoms if you have had cardiac surgery or an intervention such as angioplasty (balloon) or stent.  True  False

**REHAB INFORMATION**

Do you drink alcohol?  Yes  No If yes, how many oz per day? \_\_\_\_\_

Do you drink caffeine?  Yes  No If yes, how many 6 oz cups of coffee/tea/colas per day? \_\_\_\_\_

Do you have any orthopedic (muscle, joint or bone problems)?  Yes  No

If yes, describe: \_\_\_\_\_

What are your specific goals for cardiac rehab? \_\_\_\_\_

Do you have an Advanced Directive (i.e., Durable Power of Attorney for Health Care Decisions)?  Yes  No

If No, do you want information?  Yes  No