Do You Know Your Risk Factors for Coronary Artery Disease? Name_____

Uncontrollable Risk Factors:

Gender and Age: What is your age and gender? Risk Factor? ☐
Men over age 45/Women over age 55 Yes / No

Family History: Has a family member had a heart event? Risk Factor? ☐
Men before age 55/Women before age 65 Yes / No

Prior Heart Event: Have you suffered a prior heart event? Yes / No Risk Factor? ☐

Controllable Risk Factors:

High Blood Pressure: Are you currently taking BP medications? Yes / No Risk Factor? ☐
Do you check your BP at home? Yes / No
Goal: Systolic BP < 120mmHg / Diastolic BP < 80mmHg

High Cholesterol: Are you currently taking cholesterol medication? Yes / No Risk Factor? ☐
Date of most recent labs: _____

Smoking/Tobacco Use: Are you a current or **past** smoker? Yes / No Risk Factor? ☐
Current smoker _____ Past smoker _____ Never a smoker _____
Packs per day _____ Years: _____ Quit Date: _____

Diabetes: Do you have diabetes? Yes / No Risk Factor? ☐
Type I / Type II / Pre-Diabetes Date of most recent labs: _____

Obesity: Height: _____ Weight: _____ BMI: _____ Risk Factor? ☐
Goal Weight: _____ BMI Goal: > 19 < 25

Sedentary Lifestyle: How many minutes do you exercise? Risk Factor? ☐
Goal: Active: > 150 mins/week
What were you doing for exercise in the 2 weeks prior to your heart event?
Activity: _____ Mins/day: _____ Days/week:_____

What have you been doing for exercise since your heart event?
Activity: _____ Mins/day: _____ Days/week: _____

Are there any specific activities you want to be able to do again? _____

Stress: Risk Factor? ☐
What is currently causing you stress? _____

What do you do to relax/get rid of stress? _____

Sleep Apnea: Risk Factor? ☐
Do you have Sleep Apnea? Yes / No If yes, do you use a **CPAP** or **Oral device**?

Medications:
Are you consistently taking all your medications as prescribed? Yes / No
If you answered "No," please explain why:_____

Have you had a flu vaccine this year: Yes / No Pneumonia Vaccine in the last 5 years: Yes / No
Do you carry a list of your medications with you: Yes / No
Do you have a prescription for Nitroglycerin? Yes / No
Do you carry your Nitroglycerin with you? Yes / No
Do you have any allergies to medications? Yes / No If yes, please list:_____
_____

Cardiologist: _____ Primary Doctor: _____

Emergency contact: _____ Phone Number: _____

Signs/Symptoms: What symptoms did you experience at the time of your cardiac event?

_____

If you do have any unusual symptoms, especially those listed above:

- Stop any activity you're doing, sit down and rest.
- Sit or lay down, take Nitroglycerin every 3-5 minutes up to a total of no more than 3 times in 15 minutes.
- If symptoms persist, call the paramedics (911).
- If symptoms are relieved, call your physician to inform him/her of the incident.
- If you do not have an Rx for Nitroglycerin, stop activity, sit down and rest for 10-15 minutes. If symptoms are still present, call your MD or call 911, depending on the severity of the symptoms.
- Please report any unusual symptoms to a cardiac rehab staff member whether it occurs in rehab or at home!

Caffeine/Alcohol: Do you drink caffeine? Yes / No If yes, ounces per day _____

Do you drink alcohol? Yes / No If yes, ounces per day or week _____

Orthopedic Issues: Do you have any orthopedic issues we should be aware of: Yes / No

If "Yes," please explain: _____

Do you currently use a cane or walker? Yes / No

Goals: What goals would you like to achieve while in the cardiac rehab program? (Pick up to 3)

◯ Begin a home exercise program	◯ Blood Pressure Control	◯ Diabetes Management
◯ Improve my nutrition	◯ Stop smoking	◯ Return to previous activities
◯ Lose weight	◯ Symptom management	◯ Increase fitness level
◯ Improve cholesterol numbers	◯ Stress Management	◯ Other _____

Do you have any specific questions or concerns that you would like to discuss with a staff member?

_____
_____