About You

Name: _____

Date: _____

Reviewed by staff: _____

HEART AND RISK

Coronary Artery Disease or Heart Disease (check all that apply):

- ☐ happens all of a sudden
- ☐ is a progressive disease
- ☐ is cured by bypass surgery or stent
- ☐ may be stopped or slowed by lifestyle changes and medications
- ☐ may be reversible

All of the following are risk factors for heart disease. Please check **YOUR** own risk factors

- ☐ blood fat levels (lipids/cholesterol)
- ☐ hypertension (high blood pressure)
- ☐ overweight
- ☐ stress and how you cope
- ☐ type A personality (intense, driven, find it hard to relax)
- ☐ sleep apnea
- ☐ high fat diet
- ☐ not enough physical activity
- ☐ gender (male)
- ☐ family history
- ☐ diabetes
- ☐ smoking

All of the following can be symptoms of heart problems. Which have **YOU** experienced?

- ☐ chest pressure
- ☐ shoulder pain or discomfort
- ☐ arm pain or discomfort
- ☐ swelling in the legs
- ☐ jaw pain or discomfort
- ☐ neck or throat pain or discomfort
- ☐ unable to sleep lying flat
- ☐ back/shoulder blade pain or discomfort
- ☐ fatigue
- ☐ sweating
- ☐ nausea
- ☐ shortness of breath

Other:_____

What do you do if chest discomfort should occur?

- ☐ Stop any activity in which I am involved and sit down for 5 minutes to rest
- ☐ Take nitroglycerin (tablet or spray) every 5 minutes, no more than 3 times. If pain continues, call 911. If the discomfort is relieved, call your physician to let them know about the pain.
- ☐ Continue activity and try to work through it.
- ☐ If discomfort continues, drive myself to the hospital.

MEDICATIONS

Check off the statements concerning medications which 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.

What might be some the reasons you would miss taking your medications:

- ☐ memory
- ☐ "too confusing"
- ☐ "it does not work"
- ☐ financial
- ☐ fear of side effects
- ☐ Dosage frequency
- ☐ "I do not need it"

Next Page ➡

St. Joseph Health
St. Jude Medical Center

101 East Valencia Mesa Drive • Post Office Box 4138
Fullerton, California 92835-4138 • Telephone (714) 871-3280

MRCARD

BLOOD PRESSURE

In the past, were you ever told you had high blood pressure? ☐ Yes ☐ No

- If **YES**, did you take medication for your blood pressure? ☐ Yes ☐ No

If **YES**, name of medication(s) _____

Do you check your blood pressure at home? ☐ Yes ☐ No

- If **YES**, How often? _____ (e.g. Once daily, twice daily, etc.)

Latest reading? _____ What would you consider a "good" blood pressure reading?_____

NUTRITION

Did you ever follow a meal plan in the past? ☐ Yes ☐ No

If **YES**, please check all that you have followed:

☐ American Heart Association	☐ Ornish Reversal	☐ Ornish Spectrum
☐ Carbohydrate counting	☐ Bariatric	☐ DASH Diet
☐ Dietary Exchanges	☐ Food Guide Pyramid	☐ Gluten-Free
☐ High Protein/Low Carb	☐ Low Calorie	☐ Low Fat
☐ Portion Control	☐ Renal Diet	☐ Weight Watchers

☐ Sodium Restriction If Sodium Restriction, maximum allowed in one day: _____ mg

☐ Fluid Restriction If Fluid restriction, maximum allowed in one day: _____ ounces

Are you following a meal plan now? ☐ Yes ☐ No What type?: _____

Eating habits: Number of meals per day: _____ Number of snacks per day: _____

How often do you eat out (restaurants, drive-thru, etc.) _____ times per week

Do you drink alcohol? ☐ Yes ☐ No If **YES**, ☐ Daily ☐ Weekly ☐ Special Occasions

Number of drinks per day: _____Type: _____

Do you consume caffeine? ☐ Yes ☐ No How many 6 ounce cups of coffee per day? _____

CHOLESTEROL

Were you ever told your cholesterol level was high? ☐ Yes ☐ No

Did you know your cholesterol levels prior to your heart event?

I don't know _____ Total = _____ HDL = _____ LDL = _____ Triglycerides = _____

Did you take medication for your cholesterol before your cardiac event? ☐ Yes ☐ No

If **YES**, name of medication: _____

Next Page ➡

DIABETES

Do you have diabetes? ☐ Yes ☐ No If **YES**, how many years? _____

How often do you check your blood sugar? _____ times per day

Have you ever experienced hypoglycemia (symptomatic LOW blood sugar) ☐ Yes ☐ No

If **YES**, please describe:_____

Have you ever experienced hyperglycemia (symptomatic HIGH blood sugar) ☐ Yes ☐ No

If **YES**, please describe: _____

SOCIAL

Do you practice any stress management techniques? ☐ Yes ☐ No

☐ Yoga ☐ Meditation ☐ Visualization/Imagery ☐ Progressive Relaxation
☐ Tai Chi ☐ Stretching ☐ Breathing Techniques ☐ Other: _____

Frequency_____ Duration: _____
(times per week) (minutes each time)

Stress Level: ☐ High ☐ Medium ☐ Low

Stress Related to:
☐ Major life event ☐ Nagging unfinished tasks ☐ Feeling overwhelmed ☐ Lack of time
☐ Lack of sleep ☐ Ongoing, low level stress at home and/or work

Other: _____

Have you been sad, lonely or felt "depressed" since your cardiac event? ☐ Yes ☐ No
- Do you take medication to help with your feelings? ☐ Yes ☐ No

How would you describe your relationships? ☐ Safe or ☐ Unsafe

If employed, have you already returned to work? ☐ Yes ☐ No ☐ Not employed

If **YES**, when did you return? Date: _____

If **NO**, do you have a return to work goal date? Date: _____

TOBACCO

☐ Never a smoker ☐ Former Smoker ☐ Current every day ☐ Current some days

Average packs per day: _____ Years using tobacco: _____ Years using oral tobacco:_____

Date quit : _____

PHYSICAL ACTIVITY

BEFORE your cardiac event:

Did you participate in regular cardiovascular/aerobic exercise? ☐ Yes ☐ No

Type _____ Frequency_____ Duration: _____
(e.g. walk, swim, bike,etc.) (times per week) (minutes each time)

Did you participate in regular strength training? ☐ Yes ☐ No

Type _____ Frequency_____ Duration: _____
(e.g. walk, swim, bike, weights, etc.) (times per week) (minutes each time)

☐ I did **NOT** exercise What prevented you from exercising?: _____

Do you have a gym or health club membership? ☐ Yes ☐ No Name: _____

Do you have home exercise equipment? If **YES**, describe: _____

AFTER your cardiac event:

Type _____ Frequency_____ Duration: _____
(e.g. walk, swim, bike,etc.) (times per week) (minutes each time)

☐ I am **NOT** exercising at this time
If **NOT** exercising now, what limits you? _____

Do you have any work-related physical demands? Please Describe: _____

Do you have any orthopedic (muscle, joint or bone) problems?

Please describe: _____

_____

Do you have difficulty standing from a chair without using your hands to help? ☐ Yes ☐ No

Have you fallen in the last year? ☐ Yes ☐ No

Are you afraid you might fall or consider yourself at risk? ☐ Yes ☐ No

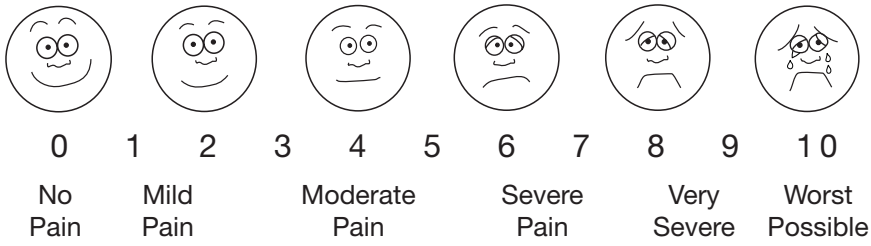
PAIN

Use the 0 to 10 pain scale (0 = no pain; 10 = worse possible) below to rate the level:

- Are you having any pain at this time? ☐ Yes level _____ ☐ No

Location: _____

- If you have a chronic pain condition, at what level are you still able to function? Level _____



Since your initial hospitalization, have you had any emergencies or complications? ☐ Yes ☐ No

Describe: _____

PREFERRED METHOD OF LEARNING

When learning new things, how do you like to learn?

☐ Computer ☐ Reading ☐ Lecture/Audio ☐ No Preference
☐ Hands on/Demo ☐ Video ☐ Group Discussion ☐ Listening

Please, check the lifestyle changes you believe you have already made:

☐ stopped smoking
☐ learned relaxation methods
☐ decreased saturated fats in diet
☐ started taking medications as prescribed
☐ read books on how to decrease my risk factors
☐ lost weight
☐ decreased food portions or total calories in diet
☐ started exercising regularly
☐ read books on how to lose weight
☐ other: _____

Education Level:

☐ Eighth grade or less ☐ Technical training ☐ Post-grad study
☐ Some HS ☐ Some college/university ☐ Unknown
☐ HS graduate ☐ College/university graduate ☐ Prefers not to state

GOALS

Please think of 3 goals you would like to achieve?

1. _____

2. _____

3. _____

HEALTHCARE

Would you like information on an Advanced Directive? ☐ Yes ☐ No

Done!

Center for Epidemiological Studies Depression Scale (CES-D)

Date: _____

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you've felt this way during the past week. Respond to all items.

Place a check mark ( ) in the appropriate column. During the past week	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with the help from my family.				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not "get going"				

Source: Radloff, L.S. (1977). The CES-D scale: A self=report depression scale for research in the general population. Applied Psychological Measurement, 1: 385-401.

DARTMOUTH COOP GENERAL HEALTH QUESTIONNAIRE

Name: _____ Date: _____

PHYSICAL FITNESS

During the past 4 weeks…
What was the hardest physical activity you could do for at least 2 minutes?

Very heavy, (for example) • Run, fast pace • Carry a heavy load upstairs or uphill (25 lbs/10kgs)	1
Heavy, (for example) • Jog, slow pace • Climb stairs or a hill moderate pace	2
Moderate, (for example) • Walk, medium pace • Carry a heavy load level ground (25 lbs/10kgs)	3
Light, (for example) • Walk, medium pace • Carry light load on level ground (10 lbs/5kgs)	4
Very light, (for example) • Walk, slow pace • Wash dishes	5

FEELINGS

During the past 4 weeks…
How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

DAILY ACTIVITIES

During the past 4 weeks…
How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?

No difficulty at all	1
A little bit of difficulty	2
Some difficulty	3
Much difficulty	4
Could not do	5

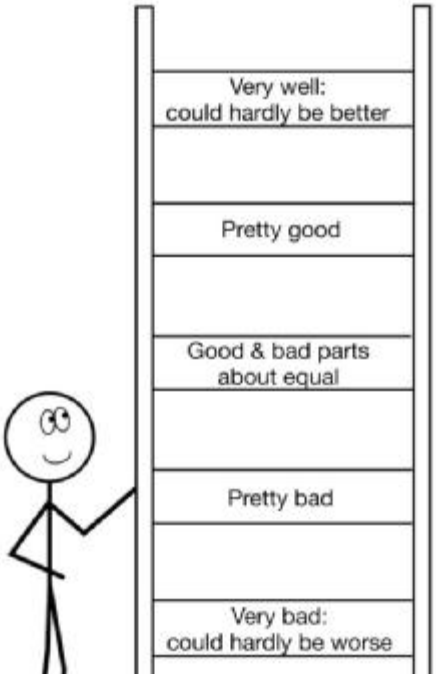
SOCIAL ACTIVITIES

During the past 4 weeks…
Has your physical and emotional health limited your social activities with family, friends, neighbors or groups?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

QUALITY OF LIFE

How have things been going for you during the past 4 weeks?



Comments:

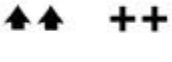
PAIN

During the past 4 weeks…
How much bodily pain have you generally had?

No pain		1
Very mild pain		2
Mild pain		3
Moderate pain		4
Severe pain		5

CHANGE IN HEALTH

How would you rate your overall health now compared to 4 weeks ago?

Much better		1
A little better		2
About the same		3
A little worse		4
Much worse		5

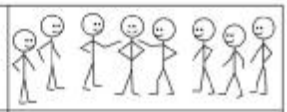
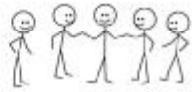
OVERALL HEALTH

During the past 4 weeks…
How would you rate your health in general?

Excellent		1
Very good		2
Good		3
Fair		4
Poor		5

SOCIAL SUPPORT

During the past 4 weeks…
Was someone available to help you if you needed and wanted help? For example if you
- felt nervous, lonely, or blue
- got sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores
- needed help just taking care of yourself

Yes, as much as I wanted		1
Yes, quite a bit		2
Yes, some		3
Yes, a little		4
No, not at all		5

Name:_____ Date:_____

Duke Activity Status Index (DASI)

Item	Activity			
1	Can you take care of yourself (eating, dressing, bathing or using the toilet)?	Yes	No	2.75
2	Can you walk indoors such as around your house?	Yes	No	1.75
3	Can you walk a block or two on level ground?	Yes	No	2.75
4	Can you climb a flight of stairs or walk up a hill?	Yes	No	5.50
5	Can you run a short distance?	Yes	No	8.00
6	Can you do light work around the house like dusting or washing dishes?	Yes	No	2.70
7	Can you do moderate work around the house like dusting or washing dishes	Yes	No	3.50
8	Can you do heavy work around the house like scrubbing floors or lifting and moving heavy furniture?	Yes	No	8.00
9	Can you do yard work like raking leaves, weeding or pushing a power mower?	Yes	No	4.50
10	Can you have sexual relations?	Yes	No	5.25
11	Can you participate in moderate recreational activities like golf, bowling, dancing, doubles tennis or throwing a baseball or football?	Yes	No	6.00
12	Can you participate in strenuous sports like swimming, singles tennis, football, basketball or skiing?	Yes	No	7.50

For Staff Use: ***SUM _____(max 58.2)***

Estimated max MET level = (0.123 * SUM) + 2.74 = _____

Reference: Hlatky MA, Boineau RE, Higginbotham MB, et al. A brief self-administered questionnaire to determine functional capacity (the Duke Activity Status Index). American Journal of Cardiology 1989; 64: 651-654

♥RATE YOUR PLATE♥

Think about the way you usually eat. For each food choice, put a check mark in column A, B or C.
Bring the completed form to your next clinic visit.

	A	B	C
1. MEAT CUTS* *fresh beef, pork, lamb, veal*	☐ **Usually eat:** lean cuts from the round, loin or leg; ham Or, **seldom eat meat**.	☐ **Sometimes eat:** higher-fat cuts, such as chuck, ribs, brisket, T-bone steak, prime rib	☐ **Usually/often eat:** higher-fat cuts
2. CHICKEN, TURKEY*	☐ **Usually eat:** **without** skin	☐ **Sometimes eat:** **with** skin	☐ **Usually eat:** **with** skin
3. GROUND MEAT & POULTRY*	☐ **Usually eat:** 5-7% fat (93-95% lean); ground turkey breast Or, **seldom eat**.	☐ **Usually eat:** 10-15% fat; ground turkey (dark & white meat)	☐ **Usually/often eat:** regular ground meat, with 20% fat or more
4. PROCESSED MEAT & POULTRY* *cold cuts, hot dogs, sausage, breakfast meats*	☐ **Usually eat:** lower-fat choices from lean meat or poultry; veggie breakfast links Or, **seldom eat**.	☐ **Sometimes eat:** higher-fat choices, such as salami, bologna, hot dogs, bacon, sausage	☐ **Usually/often eat:** higher-fat choices
5. PORTION SIZE OF MEAT & POULTRY* *cooked or processed*	☐ **Usually eat:** small portions (≤ 3 oz.) deck of cards size	☐ **Usually eat:** medium portions (4-6 oz.)	☐ **Usually/often eat:** large portions (7 oz. or more)
6. FISH, SHELLFISH*	☐ **Usually eat:** twice a week or more, especially oily fish like salmon, herring or sardines	☐ **Usually eat:** any type once a week	☐ **Usually eat:** any type less than once a week
7. COOKING METHOD* *for poultry, fish, meat*	☐ **Usually:** cook without added fat or use vegetable oil spray	☐ **Sometimes:** cook with added fat or deep fry	☐ **Usually/often:** cook with added fat or deep fry
8. MEATLESS MEALS *veggie burgers, vegetable or bean soups, meatless spaghetti sauce, tofu, rice & beans*	☐ **Usually eat:** twice a week or more	☐ **Usually eat:** less than twice a week	☐ **Rarely eat:** meatless meals
9. WHOLE EGGS*	☐ **Usually eat:** 3 or less a week OR egg substitutes OR egg whites only	☐ **Sometimes eat:** 4 or more a week	☐ **Usually eat:** 4 or more a week
10. MILK *includes yogurt, cream*	☐ **Usually use:** 1% or skim milk, fat-free or low-fat yogurt, fat-free ½ & ½	☐ **Sometimes use:** 2% or whole milk, full-fat yogurt, regular ½ & ½	☐ **Usually use:** 2% or whole milk, full-fat yogurt, light cream
11. CHEESE* *includes cheese for pizza, sandwiches, snacks, mixed dishes, etc.*	☐ **Usually eat:** reduced-fat or part-skim Or, **seldom eat.**	☐ **Sometimes eat:** regular cheese, such as cheddar, Swiss, and American	☐ **Usually eat:** regular cheese
12. DAIRY FOODS *1 serving = 1 c. milk or yogurt, 1½ oz. cheese*	☐ **Usually eat or drink** 2 or more servings a day	☐ **Usually eat or drink:** 1 serving a day	☐ **Rarely eat or drink**

*If you are a vegetarian, check column A for these (*) topics.

13. WHOLE GRAINS *1 serving = 1 oz slice bread; ½ English muffin; 1 c. cereal; ½ c. rice, pasta; 5 crackers; tortilla; mini bagel, 3 c. light popcorn*	☐ **Usually eat:** **3 or more servings a day**, 100% whole wheat bread & pasta, brown rice, whole grain cereals, i.e., oatmeal, raisin bran, Wheaties®	☐ **Sometimes eat:** 1 or 2 servings a day	☐ **Usually eat:** mostly refined grains, i.e., white bread, white rice, saltine crackers, corn flakes, Rice Krispies®, Special K®
14. FRUITS & VEGETABLES *includes legumes* *1 c. = medium whole fruit or potato, large tomato or ear corn, 2 c. raw leafy greens*	☐ **Usually eat:** 4-5 cups a day	☐ **Usually eat:** 2-3 cups a day	☐ **Usually eat:** 0-1 cup a day
15. COOKING METHOD *for vegetables, pasta, rice*	☐ **Usually prepare:** without fat & sauces OR use vegetable oil spray	☐ **Sometimes prepare:** with sauce, butter, margarine, oil	☐ **Usually prepare:** with sauce, butter, margarine, oil
16. FAT TYPE IN COOKING *includes baking*	☐ **Usually use:** olive or Canola oil Or, usually cook **without** added fat.	☐ **Usually use:** other oils, tub margarine	☐ **Usually use:** butter, bacon drippings, stick margarine, lard, shortening
17. SALT FROM PROCESSED FOODS	☐ **Always/usually:** *compare and choose lower-sodium options*	☐ **Sometimes:** *consider sodium content*	☐ **Rarely/never:** *consider sodium content*
18. SPREADS *added at the table on bread, potatoes, vegetables, pancakes, sandwiches, etc.*	☐ **Usually use:** spray or light tub margarine Or, **seldom use.**	☐ **Usually use:** regular tub margarine	☐ **Usually use:** butter or stick margarine
19. SALAD DRESSINGS, MAYONNAISE	☐ **Usually use:** fat-free or low-fat salad dressings & mayonnaise Or, **seldom use.**	☐ **Usually use:** light salad dressings & mayonnaise	☐ **Usually use:** regular salad dressings & mayonnaise
20. SNACK FOODS	☐ **Usually eat:** plain pretzels, light popcorn, baked chips Or, **seldom eat**.	☐ **Sometimes eat:** regular chips & popcorn, flavored pretzels	☐ **Usually/often eat:** regular chips & popcorn
21. NUTS, SEEDS *includes nut butters* *serving size =1/4 c. nuts, 2 T. peanut butter*	☐ **Usually eat:** 3 servings or more a week	☐ **Usually eat:** 1-2 servings a week	☐ **Usually eat:** 1 or less serving a week Or, **seldom eat**.
22. FROZEN DESSERTS	☐ **Usually eat:** sherbet, sorbet, fruit juice bars, low-fat ice cream or frozen yogurt Or, **seldom eat**.	☐ **Sometimes eat:** regular ice cream, ice cream bars/sandwiches	☐ **Usually eat:** regular ice cream, ice cream bars/sandwiches
23. SWEETS, PASTRIES, CANDY	☐ **Usually eat:** angel food cake, low-fat or fat-free products Or, **seldom eat**.	☐ **Sometimes eat:** donuts, cookies, cake, pie, pastry, or chocolate candy	☐ **Usually/often eat:** donuts, cookies, cake, pie, pastry or chocolate candy
24. EATING OUT *eat in or take out, any meal*	☐ **Seldom eat out** Or, **usually choose lower-fat menu items**	☐ **Usually eat:** 1-2 times a week	☐ **Usually eat:** 3 times a week or more

Find your Rate Your Plate score:

Total checks in column A =_____ x 3 =_____
Total checks in column B =_____ x 2 =_____
Total checks in column C =_____ x 1 =_____

TOTAL _____

If your score is:

58 - 72: You are making many healthy choices.

41 - 57: There are some ways you can make your eating habits healthier.

24 - 40: There are many ways you can make your eating habits healthier.

Look at your Rate Your Plate responses.

Do you have any responses in Column A? If you do, great! You are already making some heart healthy choices. Look at your responses in Columns B and C. Where you checked Column C, can you start eating more like Column B? Over time, move toward Column A.

Think about changes. Write down eating changes you are **ready to consider**.

Change #1: _____

Change #2:_____

Change #3:_____

Begin today. Make changes a little at a time. Let your new way of eating become a healthy habit.

Set goals. After discussion with your doctor, write down eating changes you are **ready to work on.**

Goal 1: _____

Goal 2:_____

Goal 3:_____