

Medical West Cardiac Rehabilitation Intake Questionnaire

Patient Name _____ Phone# (____) _____

Emergency Contact: _____ Phone# (____) _____ Relation: _____

Have you attended cardiac rehab in the past: Yes No

Are you an organ donor? Yes No

EVALUATE THE FOLLOWING AREAS:

Are you having any of the following symptoms that could be related to your heart or lung disease? (Check box if you have these signs/symptoms)

- Angina Paroxysmal Nocturnal Dyspnea (awaken with
 Claudication (leg cramping with walking) shortness of breath)
 Edema (swelling) Palpitations (fast or pounding heart)
 Fatigue Shortness of breath
 Lightheadedness Syncope (fainting)
 Orthopnea (sleep on more than 1 pillow)

Do you have

Yes No **High Blood Pressure**

Yes No **Diabetes**

Yes No **High Cholesterol**

Yes No **Heart failure**

Do you have a family history of Heart Attacks or Coronary Artery Disease? *Mother, Father, Brother, Sister*

Do you currently exercise? Yes No Type of exercise _____

If yes, how many days per week _____, how many minutes per day _____,

Are you currently on a special diet? Yes No

If yes please explain _____

Are you currently on fluid restriction: Yes No

Caffeine Intake: None Coffee Tea Soda Other _____

Cups per day (8oz) Circle 0 1 2 3 4 5 or more

In the last 7 days, how many days did you forget or did not take your medications as prescribed? ____ (0-7) *Please provide a copy of current medications with dose and frequency*

Are you having trouble getting your prescriptions filled? Yes No

Are you Allergic to any Medications? Yes No

If yes, please list _____

Have you had your: Pneumonia Vaccine in the last 5 years? Yes No

Flu Vaccine in the last year? Yes No

Have you received counseling regarding the Flu Vaccine? Yes No

Over the past six months:

of ER visits _____ Due to _____

of hospitalizations _____ Due to _____

Work Status: Current or past occupation _____

Yes, Full/Part time Unemployed Disabled Retired No

Smoking Status: Never smoked Other Tobacco: Chew/Snuff Vape Pipe

Past #of packs per day _____ # of years _____ When last smoked _____

Current # of cigarette/day _____ # of years _____

Smoking Cessation Plan: When do you plan to quit? in 1 month in 6 months

Did you try to quit in the last year? Y/N

How confident are you about remaining smoke-free? Least 1 2 3 4 5 Most

Alcohol Consumption Status: No Yes

drinks/day _____ # days/week _____ Type: Liquor Beer Wine

Substance Abuse. No Yes

When: Current Within Last year Former Type: _____ Frequency: _____

Do You Have Advanced Directives? Living Will Healthcare Power of Attorney
Would you like information on Advance Directives, Y/N?

Have you had thoughts of suicide in the past? No Yes

If yes please explain _____

Do you have any spiritual or cultural beliefs that affect your medical care? _____

Do you live alone? No Yes

Do you have a good support system? No Yes

Which apply: *Family, Spouse, Caregiver, Assisted Living, Self.*

Are you currently sexually active? No Yes

List any body pain that may interfere with your exercise programming-

Location: _____ Score 0-10: _____

Have you fallen recently or in the past 6 months ago? No Yes

Goal: For the following components of rehab, what is your personal expectation (be specific):

Exercise: _____

Diet: _____

Stress/Emotions: _____

Disease management: _____

What are your preferred learning methods? Group class Individual counseling Written material

Completed by : _____ **Date:** _____ **Time:** _____

Please mark which education topics you are most interested in learning more about:	
Healthy Eating	
Heart Disease Process	
Diabetes Control	
Health Emergency Plan	
Blood Pressure Control	
Cholesterol Control	
Heart Medications	
Physical Activity	
Quit Smoking/Dip/Chew	
Exercise Skills	
Stress Management/Emotions	
Weight Loss/Gain	

What is your highest Education Level (Circle):

Less than High School

High School Graduate

Some College/Associates Degree

Bachelor's Degree

Master's Degree

Doctoral Degree

Please provide your email address for education purposes: _____

Name: _____ pre post Date: _____

Please circle the statement that best describes your current outlook regarding the modifiable risk factors for heart disease:

Controlling blood pressure	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I've never had high blood pressure
Controlling blood sugars	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I'm not a diabetic or had elevated fasting blood sugars.
Controlling Cholesterol levels	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I've never had high cholesterol.
Stop Smoking	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I've never smoked or quit more than 6 months ago.
Stress Management	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	
Weight Loss	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I'm at goal weight.
Exercising	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	
Healthier Diet	I'm not ready to change right now	I'm thinking about doing it sometime	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months	

**Cardiac Rehabilitation
Readiness to Change Assessment**

MW0406 2020/06

Name: _____ Date: _____

Instructions: "I have some questions to ask you regarding your current level of physical activity. Your answers to these questions will help us determine your initial exercise levels. Please answer 'yes' or 'no' to each question."

Can you:	Circle	Weight
1. Take care of yourself, that is, eat, dress, bathe, or use the toilet?	Yes No	2.75
2. Walk indoors, such as around your house?	Yes No	1.75
3. Walk a block or two on level ground?	Yes No	2.75
4. Climb a flight of stairs or walk up a hill?	Yes No	5.50
5. Run a short distance?	Yes No	8.00
6. Do light work around the house like dusting or washing dishes?	Yes No	2.70
7. Do moderate work around the house like vacuuming, sweeping floors, or carrying groceries?	Yes No	3.50
8. Do heavy work around the house like scrubbing floors or lifting or moving heavy furniture?	Yes No	8.00
9. Do yardwork like raking leaves, weeding, or pushing a power mower?	Yes No	4.50
10. Have sexual relations?	Yes No	5.25
11. Participate in moderate recreational activities, like golf, bowling, dancing, doubles tennis, or football?	Yes No	6.00
12. Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?	Yes No	7.50

Duke Activity Status Index (DASI) = _____ (Sum of weights of "yes" replies)

VO₂ = _____ ml/kg/min MET Level = _____

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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.

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

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



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Rate Your Plate Survey

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11. CHEESE* includes cheese for pizza, sandwiches, snacks, mixed dishes, etc.	<input type="checkbox"/> Usually eat: reduced-fat or part-skim Or, seldom eat.	<input type="checkbox"/> Sometimes eat: regular cheese, such as cheddar, Swiss, and American	<input type="checkbox"/> Usually eat: regular cheese
12. DAIRY FOODS 1 serving: 1 c. milk or yogurt, 1 ½ oz. cheese	<input type="checkbox"/> Usually eat or drink 2 or more servings a day	<input type="checkbox"/> Usually eat or drink: 1 serving a day	<input type="checkbox"/> Rarely eat or drink
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	<input type="checkbox"/> Usually eat: 3 or more servings a day, 100% whole wheat bread & pasta, brown rice, whole grain cereals, i.e., oatmeal, raisin bran, Wheaties®	<input type="checkbox"/> Sometimes eat: 1 or 2 servings a day	<input type="checkbox"/> 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	<input type="checkbox"/> Usually eat: 4-5 cups a day	<input type="checkbox"/> Usually eat: 2-3 cups a day	<input type="checkbox"/> Usually eat: 0-1 cup a day
15. COOKING METHOD for vegetables, pasta, rice	<input type="checkbox"/> Usually prepare: without fat & sauces OR use vegetable oil spray	<input type="checkbox"/> Sometimes prepare: with sauce, butter, margarine, oil	<input type="checkbox"/> Usually prepare: with sauce, butter, margarine, oil
16. FAT TYPE IN COOKING includes baking	<input type="checkbox"/> Usually use: olive or Canola oil Or, usually cook without added fat.	<input type="checkbox"/> Usually use: other oils, tub margarine	<input type="checkbox"/> Usually use: butter, bacon drippings, stick margarine, lard, shortening
17. SALT FROM PROCESSED FOODS	<input type="checkbox"/> Always/usually: compare and choose lower-sodium options	<input type="checkbox"/> Sometimes: consider sodium content	<input type="checkbox"/> Rarely/never: consider sodium content
18. SPREADS added at the table on bread, potatoes, vegetables, pancakes, sandwiches, etc.	<input type="checkbox"/> Usually use: spray or light tub margarine Or, seldom use.	<input type="checkbox"/> Usually use: regular tub margarine	<input type="checkbox"/> Usually use: butter or stick margarine
19. SALAD DRESSINGS, MAYONNAISE	<input type="checkbox"/> Usually use: fat-free or low-fat salad dressings & mayonnaise Or, seldom use.	<input type="checkbox"/> Usually use: light salad dressings & mayonnaise	<input type="checkbox"/> Usually use: regular salad dressings & mayonnaise
20. SNACK FOODS	<input type="checkbox"/> Usually eat: plain pretzels, light popcorn, baked chips Or, seldom eat.	<input type="checkbox"/> Sometimes eat: regular chips & popcorn, flavored pretzels	<input type="checkbox"/> Usually/often eat: regular chips & popcorn



PLATE

Rate Your Plate Survey

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21. NUTS, SEEDS includes nut butters serving size =1/4 c. nuts, 2 T. peanut butter	<input type="checkbox"/> Usually eat: 3 servings or more a week	<input type="checkbox"/> Usually eat: 1-2 servings a week	<input type="checkbox"/> Usually eat: 1 or less serving a week Or, seldom eat.
22. FROZEN DESSERTS	<input type="checkbox"/> Usually eat: sherbet, sorbet, fruit juice bars, low-fat ice cream or frozen yogurt Or, seldom eat.	<input type="checkbox"/> Sometimes eat: regular ice cream, ice cream bars/sandwiches	<input type="checkbox"/> Usually eat: regular ice cream, ice cream bars/sandwiches
23. SWEETS, PASTRIES, CANDY	<input type="checkbox"/> Usually eat: angel food cake, low-fat or fat-free products Or, seldom eat.	<input type="checkbox"/> Sometimes eat: donuts, cookies, cake, pie, pastry, or chocolate candy	<input type="checkbox"/> Usually/often eat: donuts, cookies, cake, pie, pastry or chocolate candy
24. EATING OUT eat in or take out, any meal	<input type="checkbox"/> Seldom eat out Or, usually choose lower-fat menu items	<input type="checkbox"/> Usually eat: 1-2 times a week	<input type="checkbox"/> Usually eat: 3 times a week or More
Find Your Score = A+B+C	# A: X3=	# B: X2=	# C: X1=
Score	Score	Score	Score

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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? 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:



PLATE

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Rate Your Plate Survey

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Name: _____ Date of Birth: _____ Date: _____

PHYSICAL FITNESS

During the past 4 weeks...

What was the hardest physical activity you could do for at least 2 minutes?

Circle Best Answer

<p>Very heavy, (for example)</p> <ul style="list-style-type: none"> • Run, fast pace • Carry a heavy load upstairs or uphill (25 lbs/10kgs) 		1
<p>Heavy, (for example)</p> <ul style="list-style-type: none"> • Jog, slow pace • Climb stairs or a hill moderate pace 		2
<p>Moderate, (for example)</p> <ul style="list-style-type: none"> • Walk, medium pace • Carry a heavy load level ground (25 lbs/10kgs) 		3
<p>Light, (for example)</p> <ul style="list-style-type: none"> • Walk, medium pace • Carry light load on level ground (10 lbs/5kgs) 		4
<p>Very light, (for example)</p> <ul style="list-style-type: none"> • Walk, slow pace • Wash dishes 		5






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FEELINGS

During the past 4 weeks...

How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or sad.

Circle Best Answer

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






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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?

Circle Best Answer

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





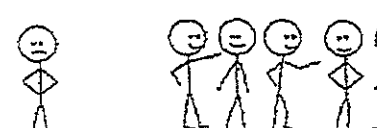
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SOCIAL ACTIVITIES

During the past 4 weeks...

Has your physical and emotional health limited your social activities with family, friends, neighbors or groups?

Circle Best Answer

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






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PAIN

During the past 4 weeks...

How much bodily pain have you generally had?

Circle Best Answer



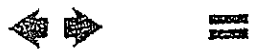


No pain		1
Very mild pain		2
Mild pain		3
Moderate pain		4
Severe pain		5

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CHANGE IN HEALTH

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

Circle Best Answer

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






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OVERALL HEALTH

During the past 4 weeks...

How would you rate your health in general?

Circle Best Answer

Excellent		1
Very good		2
Good		3
Fair		4
Poor		5

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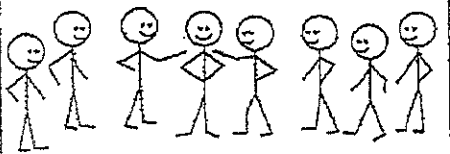
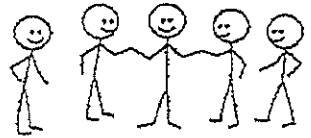
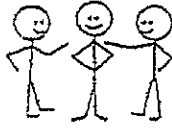


SOCIAL SUPPORT

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

Circle Best Answer

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

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QUALITY OF LIFE

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

Circle Best Answer

Very well: could hardly be better	1
Pretty good	2
Good & bad parts about equal	3
Pretty bad	4
Very bad: could hardly be worse	5

Dartmouth COOP Functional Assessment Charts/WONCA
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Score _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
---	---	---	--



Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information (MW119)

Patient Name _____ Date of Birth _____

Social Security Number _____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Medical West in writing, but if I do it will not have an effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise.

I hereby authorize Medical West to disclose health information to the following:

Release to (Name) _____ Relationship to Patient _____
Phone #1 (_____) _____ Phone #2 (_____) _____
Release to (Name) _____ Relationship to Patient _____
Phone #1 (_____) _____ Phone #2 (_____) _____

PLEASE NOTE THAT NOT ANSWERING THE QUESTIONS BELOW MAY RESULT IN THE STAFF OF MDICAL WEST LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE.

- YES NO The physicians and staff of Medical West may confirm my appointment to my answering machine at the number provided on my patient information sheet.
- YES NO The physicians and staff of Medical West may leave lab results or results of other diagnostic studies (e.g., MRI, CT, Bone Scan, etc.) on my answering machine.
- YES NO The physicians and staff may release information to my pharmacy without prior authorization in order to allow call in of a prescription.

Special Instructions _____

My signature below is acknowledgement that I have received a copy of the Medical West Privacy Notice (MR119) and that I agree to the conditions stated in this notice.

Signature of Patient/Legal Guardian/Responsible Party _____ Date _____

Printed Name of Legal Guardian/Responsible Party _____ Relationship to Patient _____

Name: _____ Date: _____ Score: _____

1. What should a normal total cholesterol level be? < _____ mg/dl.
2. What is a normal blood pressure reading? ____/____ mm/Hg
3. List 2 risk factors for heart disease:
 1. _____
 2. _____
4. List 2 ways to manage stress:
 1. _____
 2. _____
5. List 2 things you can do to prevent further progression of your heart disease:
 1. _____
 2. _____
6. Nitroglycerin for chest pain should be taken _____ minutes apart, up to _____ tablets.
7. How many times per week should you exercise? _____



Cardiac Rehabilitation
Pre/Post Program Questionnaire
MW0421 2019/08