SpecialtyHealth, Inc.
Cardiac Wellness Program©

Cardiac Health History Questionnaire

Section 1 – Participant Information

TODAY'S DATE_____

NAME (LAST)_____(FIRST)_____(MI)___

AGE_____ BIRTHDATE_____ Gender: □ MALE □ FEMALE

HOME PHONE #_____WORK PHONE #_____

E-MAIL ADDRESS_____CELL PHONE #_____

CURRENT OCCUPATION:_____

YEARS IN THIS OCCUPATION:_____EMPLOYER _____

EMPLOYER ADDRESS: _____

PRIMARY CARE PHYSICIAN (If applicable):

NAME_____

ADDRESS (STREET AND NUMBER)_____

CITY_____STATE_____ZIP CODE_____ PHONE_____

Authorization

I hereby authorize the physicians and staff involved in SpecialtyHealth's Cardiac Wellness Program to utilize my medical information obtained through the Cardiac Wellness Program for the purpose of research. Research may include individual case studies and/or compilations of group/population data, which may be published and/or presented in lectures. All personal and medical information will be kept confidential. A personal ID will be assigned to each individual participant to protect their privacy.

_____ **I DO authorize my medical and personal information to be used as part of research.**
(Initial)

_____ **I DO NOT authorize my medical and personal information to be used as part of research.**
(Initial)

SIGNATURE_____**DATE**_____

Consent to Release Medical Information

According to the HIPAA compliance for protected health information (PHI), it is necessary to provide SpecialtyHealth Clinic with the name(s) of the following individual(s) with whom they can share my protected health information (PHI). It is with my informed consent that these individuals are able to speak with, give written prescriptions and orders for procedures to, and discuss health care options with if I am unable to do so. It is also my understanding that I may revoke this consent at any time as long as the revocation is in writing with a signature, effective date and is received in the office of SpecialtyHealth Clinic.

PATIENT NAME: _____ **DATE:** _____

ADDRESS: _____

PATIENT SIGNATURE: _____

DESIGNATED INDIVIDUAL(S) AUTHORIZED TO RECEIVE PERSONAL HEALTH NFORMATION (PHI):

NAME	RELATIONSHIP TO PATIENT

SpecialtyHealth
350 W. Sixth Street, Suite 2-D
Reno, NV 89503
(775) 329-9920

Cardiac Health History Questionnaire

Name _____ **Date** _____

Section 2 – Personal Health History

Allergies (such as to medication, food, etc.):_____

_____

Current Health Problems:_____

_____

Currently Prescribed Medications:_____

_____

Currently used over-the-counter products (such as vitamins, supplements or aspirin):_____

_____

Past Surgeries:_____

_____

Other Health History:_____

_____

1. Have your ever had or been diagnosed with the following?
   - ___ Heart Attack (myocardial infarction)
   - ___ Angina pectoris or coronary artery disease
   - ___ Coronary artery surgery (angioplasty, stent, or coronary bypass)
   - ___ Stroke (TIA "small stroke" or major stroke) or coronary artery obstruction
   - ___ Peripheral artery disease (PAD, artery blockage in the legs)
   - ___ Aortic aneurysm
   - ___ Diabetes mellitus (sugar diabetes)

2. Tobacco use?
   - ___ Do you currently smoke cigarettes
   - ___ If you have quit smoking, has it been less than a month
   - ___ Any past history of tobacco use?
   - ___ Do you currently use any tobacco products?

3. Are you currently taking medications for any of the following conditions?
   - ___ High blood sugar
   - ___ Elevated blood triglycerides
   - ___ Low level of "good" cholesterol (HDL-cholesterol)
   - ___ High level of "bad" cholesterol (LDL-cholesterol)

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4. Family history?

___ Did your father or a brother develop coronary artery disease or have a heart attack before the age of 55

___ Did you mother or sister develop coronary artery disease or have a heart attack before the age of 65

Do you currently have any of the following: Yes or No for each

Yes	No		Yes	No	
□	□	Unexplained Weight Gain	□	□	Chronic Cough
□	□	Unexplained Weight Loss	□	□	Wheezing
□	□	Decreased Energy or Lethargy	□	□	Chest Discomfort or Pain with Breathing
□	□	Nausea or vomiting	□	□	Shortness of Breath with Exertion
□	□	Dental Problems	□	□	Difficulty Breathing while Lying Flat
□	□	Heartburn or Acid Reflux	□	□	Swelling of Ankles
□	□	Nervousness or Anxiety	□	□	Depression
□	□	High Blood Pressure	□	□	Palpitations or Irregular Heart Beat
□	□	Dizziness or fainting spells	□	□	Pain in calf when walking that stops with rest
□	□		□	□	

Section 3– Nutrition

In a typical day, indicate how many servings you eat or drink of the following:

	Servings	Circle the type you use		
Breads, cereals, pasta or rice	_____	Whole grain	White	
Fruits	_____	Fresh	Frozen	Canned
Vegetables	_____	Fresh	Frozen	Canned
Dairy products (milk, yogurt)	_____	Non-fat	Low-fat	Regular
Caffeine drinks	_____	Diet	Regular	
Water (8 oz.)	_____			

In a typical week, indicate how many servings you eat of the following:

	Servings
Eggs	_____
Nuts and Seeds	_____
Legumes (beans, peas, lentils)	_____
Cheese	_____
Fish	_____

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Name _____ Date _____

Red Meats _____

Chicken _____

Which of the following do you typically eat and/or use in cooking? Circle all that apply.

Butter	Stick margarine	Trans fat-free margarine	Oil-based salad dressing
Olive oil	Canola oil	Soybean Oil	Shortening
Lard	Meat drippings	Olives	Avocados Mayonnaise

In a typical week:

1. How often do you eat breakfast? (Circle) Daily 4-6 Times 2-3 Times Once Never
2. How often do you eat high-fat foods (like hamburgers, cheeseburgers, hot dogs, bacon, fried chicken or fish, fries, whole milk, sausage or chips)? (Circle) Daily 4-6 Times 2-3 Times Once Never
3. How many meals do you eat fast food? _____
4. How often do you add salt or eat salty foods? (Circle) Daily 4-6 Times 2-3 Times Once Never
5. How often do you eat highly refined foods (like chips, pastry, cookies, candy, or regular soda)? (Circle) Daily 4-6 Times 2-3 Times Once Never
6. How many times do you eat out? Breakfast _____Lunch _____Dinner _____
7. Where do you usually eat out? Check all that apply: _____ Fast Food ____ Sit-down Restaurant ____ Take out (Chinese, pizza, etc.) _____ Convenience Store (mini-mart, 7-11) _____ Other: _____

Section 4– Physical Activity

In a typical week:

1. How often do you engage in **moderate** activity, such as brisk walking, bicycling, vacuuming, or gardening? Moderate activity results in light sweating and mild increase in heart rate.

   (Circle) None or rarely 1-2 days/week 3-4 days/week 5-7 days/week
2. How long do you engage in **moderate** activity?

   (Circle) Less than 15 minutes 15-29 minutes 30-59 minutes Over one hour
3. How often do you engage in **strenuous** activity, such as running, aerobic exercise or heavy physical work? Strenuous activity results in heavy sweating and large increase in pulse or breathing rate.

   (Circle) None or rarely 1-2 days/week 3-4 days/week 5-7 days/week
4. How long do you engage in **strenuous** activity?

   (Circle) Less than 15 minutes 15-29 minutes 30-59 minutes Over one hour

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Name _____ Date _____

Indicate your current type of activity: Days Per Week Duration

Aerobics (fast walking, jogging, bicycling, etc. _____ _____ minutes

Strength training (weight lifting) _____ _____ minutes

Stretching _____ _____ minutes

Other _____ _____ _____ minutes

List any current limitations on physical activity:_____

Do you currently belong to a health club or regularly participate in exercise classes? (Circle) Yes / No

List the barriers or what gets in the way of engaging in regular physical activity:

Yes	No	
□	□	Not enough time / too busy
□	□	Not enough money
□	□	Safety concerns
□	□	No place to be active or walk
□	□	Lack of support from others
□	□	Stress
□	□	Do not like to exercise
□	□	Pain
□	□	Too tired
□	□	Work schedule
□	□	Other – List:

Section 5 – Readiness Assessment

On a scale from 1 (very low) to 10 (very high), please answer the following:

1. How important is changing your lifestyle in controlling your weight, lowering your blood sugar, reducing your blood pressure or decreasing cholesterol? _____
2. How interested are you in making lifestyle changes to improve your health? _____
3. How confident are you that you can make the necessary lifestyle changes to meet your health goals? _____

Stages of Change

Improving your current level of health often requires lifestyle change such as increasing physical activity, changing your diet, or engaging in new behaviors. Please review the stages of change below as described by Prochaska and DiClemente. Once reviewed, indicate your readiness to make lifestyle changes in the boxes below for each of the areas listed.

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Pre-contemplation – I'm not interested in making a change. I'm not sure I even need to make a change.

Contemplation – I know I should change, but I don't really want to yet. I'll think about it.

Preparation – I want to change, but I don't know how and I need some help to get started.

Action – I have recently made some changes in this area, but am sometimes tempted to fall off track.

Maintenance – I made changes in this area and have continued to keep on track.

	Pre-contemplation	Contemplation	Preparation	Action	Maintenance	Not Applicable
Quit Smoking						
Change Diet						
Increase Activity						
Lose Weight						

Please bring your completed form to your appointment. Thank you!

Patient signature _____ Date _____

Review by: _____ Date _____

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