CARDIAC REHABILITATION INTAKE FORM

PATIENT INFORMATION

Name _____ Social Security _____

Date of birth _____ Age _____ ☑Male ☐Female

Street Address _____ Apt. # _____

City _____ State _____ Zip _____ Phone # _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer _____ Title _____ Phone # _____

Emergency contact _____ Relationship _____

Phone # _____

Primary Language _____ Place of Birth _____

PRIMARY INSURANCE INFORMATION

Responsible Party Name _____ Relationship _____

Date of birth _____ Social Security _____

Employer _____ Phone # _____ Ext. _____

Title _____

SECONDARY INSURANCE INFORMATION

Responsible Party Name _____ Relationship _____

Date of birth _____ Social Security _____

Employer _____ Title _____

PHYSICIAN INFORMATION

Referring Physician _____ Surgeon _____

Please check all of the following that apply to you:

- ☐ Heart Disease
- ☐ Heart Valve Problems
- ☐ Pacemaker
- ☐ Heart failure
- ☐ Heart Block
- ☐ Hereditary Heart Defect
- ☐ Heart Murmur
- ☐ Enlarged Heart
- ☐ Previous Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Blood Clot in Legs
- ☐ Blood Clot in Lungs
- ☐ Lung Problems
- ☐ Emphysema
- ☐ Asthma
- ☐ COPD
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Stroke/TIA
- ☐ Diabetes
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ HIV Disease/Exposure
- ☐ Hepatitis (A, B, or C)
- ☐ Other:

Please provide information about previous surgeries and hospitalizations (include date or year)

Surgeries/Procedures		Hospitalizations	
Coronary Bypass	Date: _____	Admitted For:	Date:
Cardiac Cath	Date: _____	_____	_____
Angioplasty/Stent	Date: _____	_____	_____
Pacemaker	Date: _____	_____	_____
Defibrillator	Date: _____	_____	_____
Other	Date: _____	_____	_____
	Date: _____	_____	_____

Please provide information about previous testing

Stress Test	Date: _____	Location: _____
Nuclear Test	Date: _____	Location: _____
Echo	Date: _____	Location: _____
Other	Date: _____	Location: _____
	Date: _____	Location: _____

Please List All Prescription Medications

Medication	Dose	Frequency

Please List All Over the Counter Medications

Medication	Dose	Frequency

Please list any allergies and the reaction: _____

Family History

	Family Member(s) and Age
Heart Disease	
Heart Attack	
High Cholesterol	
High Blood Pressure	
Diabetes	
Sudden Death	
Cancer	
Other:	

Health Habits

Please check all that apply to you

☐ **History of Tobacco Use**
Years _____
How Many Per Day _____
Type of Product (eg. Cigarette) _____
Quit Date (If applicable) _____

☐ **History of Alcohol Use**
Years _____
How Many Per Day/Week _____
Quit Date (If applicable) _____

☐ **Exposure to second hand smoke**

Health Habits (cont.)

CAGE Questionnaire (if you checked History of Alcohol Use)

- ☐ Have you ever felt you ought to **cut down** on your drinking?
- ☐ Have people ever **annoyed** you by criticizing your drinking?
- ☐ Have you ever felt bad or **guilty** about your drinking?
- ☐ Have you ever had a drink first thing in the morning (**eye opener)** to steady your nerves or to get rid of a hangover?

☐ **History of Caffeine Use**

Years _____
Type (eg. Coffee) _____
Drinks per day _____
Quit Date (If Applicable) _____

☐ **History of Recreation Drug Use**

Years _____
Type (eg. Marijuana) _____
Frequency _____
Quit Date (If Applicable) _____

Special Diet (eg. Vegetarian, Low Fat)_____

Current Exercise Level

Type (eg. Walking)_____
Intensity _____
How Often and Duration _____

Review of Systems (please circle all that apply to you)

Cardiovascular
- ☐ Chest Pain/Discomfort
- ☐ Sudden Heart Beat Changes
- ☐ Palpitations/Racing Heart Beat
- ☐ Swelling of Feet, Ankles, Hands
- ☐ Leg Cramps at Rest
- ☐ Constituional
- ☐ Fatigue / Fever
- ☐ Chills
- ☐ Unintentional Weight Loss
- ☐ Weight Gain

Respiratory
- ☐ Wheezing
- ☐ Cough
- ☐ Blue Lips or Finger/Toe Nails
- ☐ Productive Cough/Blood in Sputum

Gastrointestinal
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Ulcers
- ☐ Diarrhea

Gastrointestinal (cont.)
- ☐ Constipation
- ☐ Black/Tarry Stool

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness or Swelling
- ☐ Weakness of Muscles/Joints
- ☐ Muscle Pain or Cramps
- ☐ Back Pain
- ☐ Leg Pain with Walking
- ☐ Limb Weakness
- ☐ Difficulty with Balance

Please list any mobility aids:_____

Neurological
- ☐ Paralysis
- ☐ Dizziness
- ☐ Numbness
- ☐ Headaches/Migraines
- ☐ Head Injury
- ☐ Convulsions/Seizures
- ☐ Tremors
- ☐ Slurred Speech

Genitorurinary
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Erection Problems

Skin
- ☐ Rash
- ☐ Itching
- ☐ Changes in Skin Color
- ☐ Varicose Veins
- ☐ Bruise Easily
- ☐ Non-Healing Sores
- ☐ Non-Healing Incisions

Hematology/Oncology
- ☐ Tendancy to Bleed
- ☐ Slow to Heal After Cuts
- ☐ Swollen Lymph Nodes

Endocrine
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Strong/Weak Appetite
- ☐ Heat/Cold Intolerance
- ☐ Dry Skin

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss/Confusion