OPTIMUM HealthCare, Inc.
P.O. Box 153178, Tampa, FL 33684
Health and Wellness Material

Congestive Heart Failure Assessment Form

Date of Birth:
Phone#:

Date:
Member Name:
Member Address:
City State Zip:

ID#:

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your disease status and ensure you are properly managing your disease.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? ❑ Yes ❑ No

If you received this form in error and don't have this disease, check the box and return the form to us in the supplied envelope without answering any of the questions below. ❑ **No, I don't have Congestive Heart Failure.**

1. Do you experience shortness of breath? (check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always
2. Do you get tired or short of breath when walking? (check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always
3. Do you have swelling in your feet, ankles, or legs? ❑ Yes ❑ No
4. If you answered yes to #3, how deep a print does it leave? (check one) ❑ ¼ inch ❑ ½ inch ❑ More than ½" ❑ None
5. Do you experience abdominal pain or swelling? (check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always
6. Does your Blood Pressure usually run higher than 140/90? (check one) ❑ Yes ❑ No ❑ Don't Know
7. Do you weigh yourself daily? ❑ Yes ❑ No **If no, do you have access to a scale?** ❑ Yes ❑ No
8. How much does your weight change in a week? (check one) ❑ 1 lb. ❑ 2 lbs. ❑ 3-4lbs. ❑ More than 4 lbs.
9. Do you take a Diuretic? (i.e: water pill) (check one) ❑ Once a day ❑ Twice a day ❑ More than twice a day ❑ None

Congestive Heart Failure Assessment Form *(continued)*

10. How often in the past year have you been to the Emergency Room due to your Congestive Heart Failure (CHF)?
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

11. How often in the past year have you been hospitalized due to your CHF?
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

12. What type of diet do you follow?
(check all that apply) ❑ Low Salt ❑ Low Fat ❑ High Potassium ❑ High Fiber ❑ No specific diet

13. Do you smoke? ❑ Yes ❑ No

14. Do you use Oxygen at home? ❑ Yes ❑ No
If yes: ❑ 1-2 liters ❑ 3-4 liters ❑ > 4 liters

15. How often have you seen your PCP in the last 6 months?
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ More than 4 times

16. How often have you seen your Cardiologist in the last year?
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ More than 4 times

17. Does your Congestive Heart Failure interfere with your daily activities?
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

18. Do you think your Congestive Heart Failure has become better or worse over the past year?
(check one) ❑ Better ❑ Worse ❑ Stayed the same

19. Who treats you for your Congestive Heart Failure?
(check all that apply) ❑ PCP ❑ Cardiologist ❑ Other

20. How would you rate your ability to take care of yourself with the support you have in place?
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor