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

Cardiovascular Assessment Form

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

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

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 health condition, 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 Coronary Artery Disease.

1. Do you experience shortness of breath? ❑ Yes ❑ No
If yes, then how often do you get short of breath?
(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

2. Do you experience chest pain? ❑ Yes ❑ No
If yes, how often do you have chest pain?
(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

3. Do you have the following: ❑ Swelling in feet, ankles or legs ❑ Poor circulation
If you have swelling, how often do your feet, ankles or legs swell?
(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

4. Have you ever had a Heart Attack?
(check one) ❑ Yes ❑ No

5. If yes, how long ago was your Heart Attack?
(check one) ❑ Less than 1 year ❑ 2-3 years ago ❑ More than 3 years ago

6. Have you ever had heart surgeries, ex. bypass, stents? ❑ Yes ❑ No

7. Does your Blood Pressure usually run higher than 140/90?
(check one) ❑ Yes ❑ No ❑ Don't Know

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Cardiovascular Assessment Form *(continued)*

8. Do you have any of the following? (check all that apply)
❑ High Cholesterol ❑ Diabetes ❑ Hypertension

9. Do you use tobacco (smoke, chew, snuff, vape or in any other form)? ❑ Yes ❑ No

10. What type of diet do you follow?
(check one) ❑ Low Salt ❑ Low Fat ❑ Heart Healthy ❑ No specific diet

11. Do you use Oxygen at home? ❑ Yes ❑ No

12. How often do you exercise per week?
(check one) ❑ 1-2 days ❑ 3-4 days ❑ 5-7 days ❑ Don't exercise regularly

13. Does your heart condition prevent you from enjoying your life?
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

14. How often have you seen your PCP in the last year for your heart condition?
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ More than 4 times

15. 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

16. How often in the past year have you been to the Emergency Room due to your heart condition?
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

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

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

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

20. What is your living situation today? (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

21. Within the past 12 months, have you worried that your food would run out before you got money to buy more?
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

22. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No