



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

Cardiovascular 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 Coronary Artery Disease.

<p>1. Do you experience shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, then how often do you get short of breath? (check one) <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always</p>
<p>2. Do you experience chest pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how often do you have chest pain? (check one) <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always</p>
<p>3. Do you have swelling in your feet, ankles, or legs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, then how often do your feet, ankle or legs swell? (check one) <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always</p>
<p>4. Have you ever had a Heart Attack? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. If yes, how long ago was your Heart Attack? (check one) <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 2-3 years ago <input type="checkbox"/> More than 3 years ago</p>
<p>6. Have you ever had heart surgeries, ex. bypass, stents? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Does your Blood Pressure usually run higher than 140/90? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know</p>

Cardiovascular Assessment Form *(continued)***8. Do you have any of the following?**

High Cholesterol Diabetes High Cholesterol & Diabetes Problems with circulation in your legs

9. What type of diet do you follow?

(check one) Low Salt Low Fat Heart Healthy No specific diet

10. Do you smoke?

Yes No

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