


H&P: Heart Failure

		Name _____	
<p>Date _____</p> <p>Age _____</p> <p>Self Reported Health ____ (1 = excellent, 5 = poor)</p> <p>To last year ____ (1 = much better)</p> <p>Activity Limitations (0 = not, 3 = very limited)</p> <p>Vigorous act ____</p> <p>Moderate act ____</p> <p>Carry groceries ____</p> <p>Stairs ____</p> <p>Kneeling ____</p> <p>Walk blocks ____</p> <p>Walk block ____</p> <p>Bathe/dress ____</p>	<p>Present Illness</p>	<p>ROS (circle positives)</p> <p>Low energy</p> <p>Sleepy</p> <p>Dizzy</p> <p>Syncope</p> <p>Chest pain</p> <p>Dyspnea</p> <p>Cough</p> <p>Edema</p> <p>Palpitations</p> <p>Night sweats</p> <p>Insomnia</p> <p>Depression</p> <p>Urine freq.</p> <p>Nocturia</p> <p>Confusion</p> <p>Weight change</p> <p>Appetite</p> <p>Arthritis</p> <p>Sex dysfunction</p> <p>Heat intol.</p> <p>Orthopnea</p>	
<p>Interferes ____ (0 = not, 4 = extreme)</p>	<p>PMHX.</p>		
<p>PMHX (circle positives)</p> <p>Hypertension</p> <p>Hypotension</p> <p>Heart attack</p> <p>Angina</p> <p>Heart failure</p> <p>Diabetes</p> <p>Renal disease</p> <p>Thyroid</p> <p>Arrhythmia</p> <p>Pacemaker</p> <p>Murmur</p> <p>Anemia</p> <p>Falls</p> <p>Syncope</p> <p>PVD</p> <p>Hi cholesterol</p> <p>Depression</p> <p>Arthritis</p> <p>Asthma/COPD</p> <p>Obesity</p>	<p>Prior Cardiac Testing/Tx.</p>	<p>Health Habits</p> <p>Tobacco _____/pk-yrs.</p> <p>Street drugs? Y N</p> <p>Alcohol _____/day</p> <p>Ever heavy? Y N</p>	
	<p>Medications</p>	<p>Exercise History</p> <p>Min/wk _____</p> <p>What kind? _____</p>	
<p>Family History (circle positives)</p> <p>Heart attack/failure</p> <p>Sudden death</p> <p>Stroke</p> <p>PVD</p> <p>Hi cholesterol</p> <p>Diabetes</p> <p>Obesity</p>	<p>Positives (PMHx, ROS, others)</p>	<p>Salt</p> <p>Salt before taste? Y N</p> <p>Salt at table? Y N</p> <p>Salty foods? Y N</p>	

Vital Signs BP sit _____ BP stand _____ P ___ P standing ___ T _____ Wt. ___ lb Ht. ___ in																
Eyes <input type="checkbox"/> nl conjunctiva & lids Pupils <input type="checkbox"/> pupils symmetrical, reactive Fundus <input type="checkbox"/> nl discs & pos elements Vision <input type="checkbox"/> acuity and gross fields intact	Abdomen <input type="checkbox"/> no masses or tenderness L/S <input type="checkbox"/> no liver/spleen enlargement Anus/rectal <input type="checkbox"/> no abnormality or masses Breasts <input type="checkbox"/> nl inspection & palpation															
ENT-External <input type="checkbox"/> no scars, lesions, masses Otoscopic <input type="checkbox"/> nl canals & tympanic membranes Hearing <input type="checkbox"/> nl to _____ Ant. Oral <input type="checkbox"/> nl teeth Oropharynx <input type="checkbox"/> nl tongue, palate, pharynx	Extrem Pulses (0 – 4) _____ Edema (0 – 4) R _____ L _____ Nails <input type="checkbox"/> no clubbing, cyanosis Skin <input type="checkbox"/> <div style="text-align: right; margin-top: 10px;"> R L  </div>															
Neck palp. <input type="checkbox"/> symmetrical without masses Thyroid <input type="checkbox"/> no enlargement or tenderness JVD <input type="checkbox"/> None v-srodiac	Neurologic Cognition <input type="checkbox"/> nl cognitive screen Affect <input type="checkbox"/> nl depression screen Crn. n <input type="checkbox"/> w/o gross deficit															
Resp. effort <input type="checkbox"/> nl without retractions Chest percuss. <input type="checkbox"/> no dullness or hyperresonance Chest palp. <input type="checkbox"/> no fremitus Auscultation <input type="checkbox"/> nl bilateral breath sounds w/o rales	<table border="0" style="width: 100%;"> <tr> <td style="width: 20%;">Check nl, circ abn</td> <td style="width: 10%;">ROM</td> <td style="width: 10%;">Strength</td> <td style="width: 10%;">Tone</td> <td style="width: 10%;">Sensory</td> </tr> <tr> <td>Upper extrem</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Lower extrem</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Check nl, circ abn	ROM	Strength	Tone	Sensory	Upper extrem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower extrem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Heart palp. <input type="checkbox"/> nl location, size Heart PMI _____ Auscultation Cardiac ausc. <input type="checkbox"/> no murmur, gallop, or rub Carotids <input type="checkbox"/> nl intensity w/o bruit Pedal pulses <input type="checkbox"/> nl posterior tibial & dorsalis pedis	Gait <input type="checkbox"/> nl Get Up and Go Test Reflexes <input type="checkbox"/> symmetrical throughout															
Comments/Abnormals																
Assessment and Plan	Educational Materials <input type="checkbox"/> Following a Low-Salt Diet <input type="checkbox"/> Leg Swelling and Fluid Retention <input type="checkbox"/> Heart Failure and Being Overweight <input type="checkbox"/> Exercising with Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> ACE Inhibitors <input type="checkbox"/> Beta-Blockers <input type="checkbox"/> Stress Testing <input type="checkbox"/> Heart Failure Evaluation <input type="checkbox"/> Heart Failure and Atrial Fibrillation <input type="checkbox"/> Information about Heart Failure <input type="checkbox"/> Blood Pressure and Heart Failure <input type="checkbox"/> Echocardiography <input type="checkbox"/> Advice for Smokers															