Medical History

Instructions To do the best possible job with your heart failure, the doctor needs details about your history, including current and past medical problems, medications, health habits, and family history. For questions that ask about how you feel, please give your best answer yourself. The information about your past conditions may be gathered from both you and your family members.

My name is: _____ ***Date:*** _____

My telephone number is: _____

First, describe the general problems you have with your health that bother you the most. Tell us the what, where, and when of your health problems. Are there things you can't do now that you wish you could?

Please give your one best answer to the following questions:

1. In general, would you say your health is:

Excellent **Very Good** **Good** **Fair** **Poor**

2. Compared to one year ago, how would you rate your health now?

Much better **Somewhat better** **About the same** **Somewhat worse** **Much worse**

3. Does your health now limit you in the following activities:

a. Vigorous activities, such as running, lifting heavy objects, or sports?

Not limited **Limited a little** **Limited a lot** **Never did this**

b. Moderate activities, such as moving a table, pushing a vacuum, bowling, or golf?

Not limited **Limited a little** **Limited a lot** **Never did this**

c. Lifting or carrying groceries?

Not limited **Limited a little** **Limited a lot** **Never did this**

d. Climbing stairs?

Not limited **Limited a little** **Limited a lot** **Never did this**

e. Bending, kneeling, or stooping?

Not limited **Limited a little** **Limited a lot** **Never did this**

f. Walking several blocks?

Not limited **Limited a little** **Limited a lot** **Never did this**

g. Walking one block?

Not limited **Limited a little** **Limited a lot** **Never did this**

h. Bathing or dressing yourself?

Not limited **Limited a little** **Limited a lot** **Never did this**

Code	0	1	2		

4. During the past 4 weeks, how much has your health interfered with your normal or desired level of work or social activities?

	Not at all	Slightly	Moderately	Quite a bit	Extremely
Code	0	1	2	3	4

Past Medical History

Have you been affected by any of the following problems or conditions? If so, when was it first found?

Condition	When?	Yes	No
High blood pressure		☐	☐
Low blood pressure		☐	☐
Heart attack		☐	☐
Angina or coronary disease		☐	☐
Heart failure		☐	☐
Diabetes		☐	☐
Kidney failure or trouble		☐	☐
Thyroid disease		☐	☐
Heart rhythm problems		☐	☐
Pacemaker		☐	☐
Heart murmur		☐	☐
Anemia or low blood iron		☐	☐
Passing out		☐	☐
Falls		☐	☐
Poor circulation		☐	☐
High cholesterol		☐	☐
Depression		☐	☐
Arthritis		☐	☐
Asthma or lung trouble		☐	☐
Overweight		☐	☐

Current Medical History

Please list the medical conditions currently affecting you or that you are currently receiving treatment for.

Condition	When Did It Begin?

Psychiatric History

Please list all psychiatric conditions or treatments you have had, with the approximate date of onset for each.

Condition or Treatment	Date

Operations

Please list all operations with the date of operation.

Operation	**Date**

Hospitalizations

List the reason and month/year for hospitalizations in the past 10 years.

Reason	**Month/Year**

Family History

Please indicate which family members have had any of the following medical conditions (give the relationship to you, not the relative's name).

Condition	**Family Member(s)**
Heart disease/heart attacks	_____
Sudden death	_____
Stroke	_____
Poor circulation	_____
High cholesterol	_____
Diabetes	_____
Obesity	_____
Heart failure	_____

Health Habits

If you ever smoked, how many packs per day and for how many years? _____

If you no longer smoke, when did you quit?

Have you ever used "street" drugs?

_____ No _____ Yes

Do you drink alcoholic beverages on most days?

_____ No _____ Yes

If yes, how many drinks per day, usually?
(1 drink is 1 beer, 6 oz of wine, or 2 oz of hard liquor)

_____

Have you ever been a heavy drinker (6 drinks a day or more)?

_____ No _____ Yes

Exercise History

In the last few months, how much time each week did you spend in at least moderate exercise?

< 15 min. 15 – 60 min. 60 – 120 min. > 120 min.

Moderate exercise can be walking, bicycling, swimming, or heavy housework (vacuuming, cleaning). For example: 30 minutes per day, 3 days a week would be 90 minutes total for the week.

What kind of exercise activities do you do?

_____

_____

_____

_____

Salt

Condition	**Yes**	**No**
Do you add salt before you taste your food?	☐	☐
Do you usually salt food at the table?	☐	☐
Do you eat foods from the following list on most days (don't count low-salt versions)?	☐	☐

- Processed meats (*luncheon meats, bacon, sausage*)
- "Fast food"
- Cheeses
- Canned vegetables
- TV dinners or other prepared meals
- Chips or crackers
- Pastries or donuts

Medication History

Please list all **prescription** medicines that you are currently taking.

Name of Medication	**Strength and Times per Day**

Please list all **over-the-counter** medicines that you are currently taking at least once a week.

Name of Medication	**Strength and Times per Day**

Review of Symptoms

Have you been bothered by any of the following problems in the past few months? Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the line empty if the problem has not occurred.

Problem	**Description, Date(s)**
Lack of energy	
Daytime sleepiness	
Dizziness	
Passing out	
Chest pain or discomfort	
Shortness of breath	
Cough	
Leg swelling	
Palpitations or skipped beats	
Sweating at night	
Trouble sleeping	
Depression or sadness	
Frequent or nighttime urination	
Confusion	
Sudden weight loss or gain	
Loss of appetite	
Joint pains or arthritis	
Problems having sex	
Trouble with the heat	
Prop up on pillows to sleep	