CEDARS-SINAI
HEART INSTITUTE

PREVENTIVE AND REHABILITATIVE CARDIAC CENTER

OUTPATIENT SCREENING QUESTIONNAIRE

PATIENT ID

Name: ______________________________

Date Completed: ______________________________

INSTRUCTIONS: This questionnaire will provide information needed to evaluate you for the Cardiac Rehabilitation Program. Your answers will help the rehabilitation staff understand how your condition has affected your life. This information is confidential and will be used to provide you the best care. After you have completed and returned the questionnaire, the clinical staff will meet with you to discuss the program.

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DEMOGRAPHICS

Name: ____________________ **Age:** __________

Primary language: ____________________ **Height:** __________ **Weight:** __________

Current or most recent occupation: ____________________

Employment status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Homemaker ☐ Retired ________ years
☐ Unemployed ________ years due to ____________________

Relationship status: ☐ Single ☐ Separated ☐ Married ☐ Widowed ☐ Domestic partner

With whom do you live? Name: ____________________ Relationship: ____________________

DOCTORS

NAME	ADDRESS	PHONE
INTERNIST		
CARDIOLOGIST		
OTHER		

ALLERGIES ☐ No known allergies

NAME	REACTION

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MEDICATIONS

List all medications you currently take, including over the counter and vitamins.

NAME OF MEDICATION	DOSAGE	How many times/day were you told to take the medicine?	Specify the time of day you take the medicine
			☐ AM ☐ PM
			☐ AM ☐ PM
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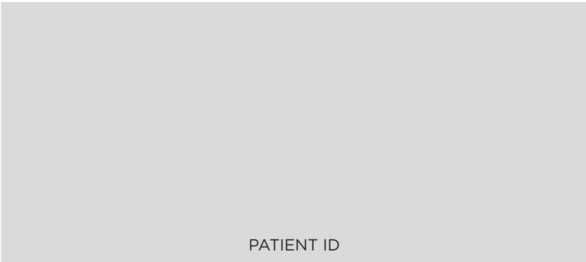

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HEALTH HISTORY

How many close blood relatives (parent, brother, sister or child) have had coronary heart disease before the age of 60? ________

Check if you have you ever been told that you had any of the following, and specify the year diagnosed.

☐ High blood pressure Year diagnosed: ____________ Treated: ☐ Yes ☐ No
☐ Sugar diabetes Year diagnosed: ____________ Treated: ☐ Yes ☐ No
☐ High cholesterol Year diagnosed: ____________ Treated: ☐ Yes ☐ No
☐ High triglycerides Year diagnosed: ____________ Treated: ☐ Yes ☐ No

What was your most recent cholesterol level? ____________ ☐ Unknown Approximate date: ____________
What was your highest cholesterol level? ____________ ☐ Unknown Approximate date: ____________

SOCIAL HISTORY

Did you ever smoke cigarettes? ☐ Yes ☐ No **(If yes, please answer the following.)**

How many years did you or have you smoked? ________

On the average, at your maximum, how many packs per day did you smoke?
☐ Less than ½ pack per day ☐ ½ to less than 1 pack per day ☐ 1 pack per day ☐ Greater than 1 pack per day

Have you stopped smoking entirely? ☐ Yes ☐ No **If yes, date stopped:** ____________ (mo/day/yr)
If no, please answer the following:
On the average, how many packs per day do you presently smoke?
☐ Less than ½ pack per day ☐ ½ to less than 1 pack per day ☐ 1 pack per day ☐ Greater than 1 pack per day

Does anyone who lives with you smoke? ☐ Yes ☐ No

Prior to your recent cardiac illness, did you drink alcoholic beverages? ☐ Yes ☐ No **(If yes, please answer the following.)**

How often? ☐ Daily ☐ 2-3 times/week ☐ Weekly ☐ Monthly

When you did drink, how many drinks did you have per day? ________ (1 drink = 4 oz. wine, one shot hard liquor or 12 oz. beer)

NUTRITION

Prior to your recent cardiac illness:

How many servings of fruit or fruit juice did you consume per day? ________
(A serving equals one piece of fruit, one cup raw fruit, or ½ cup canned fruit or fruit juice.)

How many servings of vegetables or vegetable juice did you consume per day? ________
(A serving equals one cup raw or ½ cup cooked vegetables or vegetable juice.)

How many servings of legumes (dried peas and beans like garbanzo, split peas, lentils, etc.) did you eat per week? ________
(A serving equals ½ cup cooked beans or one cup bean soup.)

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ACTIVITY

Prior to your recent cardiac illness, did you do any of the following activities on a regular basis?

☐ Walking for exercise
☐ Jogging or running
☐ Hiking
☐ Gardening or yard work
☐ Housework
☐ Calisthenics or general exercise
☐ Aerobics or aerobic dancing
☐ Other dancing
☐ Golf
☐ Tennis
☐ Bowling
☐ Bicycle riding
☐ Swimming or water exercises
☐ Horseback riding
☐ Handball, racquetball or squash
☐ Sexual intercourse

If you have done any other exercises, sports or physically active hobbies in the past two weeks other than the ones listed above, please list them: ____________________

STRESS ASSESSMENT

Prior to your recent cardiac illness, did you perform stress reduction techniques or exercises (for example, breathing exercise, yoga, meditation, prayer?) ☐ Yes ☐ No

How often? ☐ Several times per day ☐ Almost every day ☐ Once or twice a week ☐ Rarely ☐ Never

What type of stress reduction?

☐ Progressive muscle relaxation ☐ Breathing exercise/visualization ☐ Meditation ☐ Prayer ☐ Other

In the five years prior to your recent cardiac illness, how often have you experienced stress (including tension, irritability, anxiety or sleeping difficulties) as a result of conditions at work or home?

☐ Never ☐ Sometimes ☐ Often ☐ Always during the past year ☐ Always during the past five years

CARDIAC HISTORY

What year was your heart disease first discovered? __________ ☐ Unknown

Which of the following happened first? ☐ Angina/chest discomfort ☐ Abnormal treadmill stress test or EKG ☐ Coronary angiogram ☐ Heart attack ☐ Other

Have you ever had anginal pain or chest discomfort? ☐ Yes ☐ No

If yes, approximately when did this begin? ______________ (mo/day/yr)

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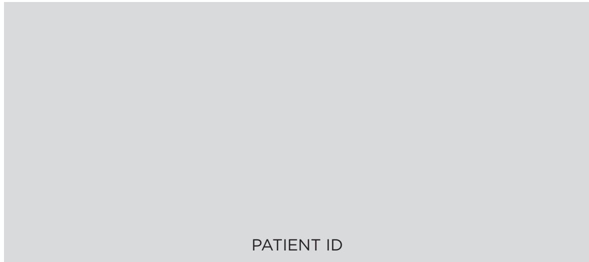

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CARDIAC HISTORY: (CONTINUED)

Please check if you have ever had any of the following, and at which hospital you were treated for that problem.

Heart Attack ☐ Never ☐ ________ times

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Coronary Angiogram ☐ Never ☐ ________ times

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Coronary Balloon Angioplasty, Laser or Stent Placement (PTCA) ☐ Never ☐ ________ times

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Heart Surgery ☐ Never ☐ ________ times

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Heart Failure ☐ Never ☐ ________ times

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

Cardiomyopathy ☐ Never ☐ ________ times

Date: ________________ Hospital: ________________

Date: ________________ Hospital: ________________

For your most recent cardiac event, how many days were you in the hospital? ________

What was the date of your most recent exercise stress test? ____________ (mo/day/yr)

What other medical problems have you had? ________________

____

____

____

Do you have a pacemaker/ICD? ☐ Yes ☐ No

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CURRENT SYMPTOMS

Currently, when do you experience fatigue?
☐ Never ☐ Even at rest ☐ During moderate to strenuous physical activity ☐ During ordinary daily activity

Currently, when do you experience shortness of breath?
☐ Never ☐ Even at rest ☐ During moderate to strenuous physical activity ☐ During ordinary daily activity

Please complete the rest of this section only if you have had a recent surgery, angioplasty or heart attack; otherwise, skip to the next section.

Since your recent surgery, angioplasty or heart attack, have you had any pain or discomfort above your waist? (Please answer even if you are entering the program for something other than the above.) ☐ Yes ☐ No

Where does your pain occur? ☐ Center of chest ☐ Left side of chest ☐ Neck or jaw ☐ Left arm ☐ Other

Does most of your pain or discomfort occur during physical exertion and/or emotional distress? ☐ Yes ☐ No

Does your pain or discomfort most often go away within 10 minutes if you rest or take nitroglycerin? ☐ Yes ☐ No

If you recently had heart surgery, do you think this is incision pain? ☐ Yes ☐ No

I have completed this questionnaire to the best of my knowledge.

Patient Signature	Date	Time

FOR CLINICAL USE ONLY

I have reviewed this questionnaire with the patient today:

Staff Printed Name/Title	Signature	Date	Time