Brigham and Women's Cardiac Rehabilitation
Patient Self-Assessment Form

Mass General Brigham
Brigham and Women's Faulkner Hospital

PATIENT IDENTIFICATION AREA

Date:

BACKGROUND INFORMATION:

Name:	**DOB:**

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living in a committed relationship

Job / Occupation Status:
☐ Currently Working ☐ Retired ☐ Disabled ☐ Seeking Employment
Occupation *(if applicable)*: _____

CARDIAC RISK FACTORS AND PRESENT HEALTH STATUS

1. **Do you have any problems with your cholesterol?** ☐ Yes ☐ No
   If "yes", for how many years? _____

2. **Do you have any problems with your blood pressure?** ☐ Yes ☐ No
   If "yes", for how many years? _____
   Do you monitor your blood pressure at home? ☐ Yes ☐ No

3. **Do you currently smoke cigarettes?** ☐ Yes ☐ No
   If "yes", how many do you smoke daily? _____
   If "yes", are you interested in quitting? ☐ Yes ☐ No

4. **Do you currently smoke cigars, pipes, or chew tobacco?** ☐ Yes ☐ No
   If "yes", how many and how often per day? _____

5. **If you do not currently smoke, did you smoke in the past?** ☐ Yes ☐ No
   If "yes", when did you quit? _____
   Have you quit more than once? ☐ Yes ☐ No

6. **Have you ever used any recreational drugs (marijuana, cocaine, etc)?** ☐ Yes ☐ No
   If "yes", please describe: _____

7. **Do you have diabetes or an elevated blood sugar (glucose) level?** ☐ Yes ☐ No
   If "yes", for how many years? _____
   Is your diabetes controlled by (check all that apply): ☐ Diet ☐ Oral Meds ☐ Insulin

8. **Do you have a family history of heart disease?** ☐ Yes ☐ No
   ** Family history means that your father or brother that was younger than 55 at the onset of heart disease (angina, heart attack, stent, coronary artery bypass surgery) or that your mother or sister was younger than 65 at onset.*

   If "yes": ☐ *Father (Age: _____)* ☐ *Mother (Age: _____)*
   ☐ *Brother(s) (Age: _____)* ☐ *Sister(s) (Age: _____)*

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CARDIAC HISTORY

Have you had any of the following? *(please check all that apply and include onset date)*	
	Date
☐ Angina/chest pain (If "yes", please describe):	
Symptoms:	
How often:	
What brings it on?	
How is it relieved?	
☐ Heart Attack	
☐ Coronary Artery Bypass Surgery	
☐ Angioplasty With/Without Stent(s)	
☐ Heart Valve Surgery	
☐ Heart Transplant	
☐ AICD/Pacemaker	
☐ Congenital Heart Defect	

PAST HEALTH STATUS

1. Do you have any of the following? *(please check all that apply)*		
☐ Arthritis	☐ Chronic Pain	☐ Seizure
☐ Anxiety/Depression	☐ Dizziness / Fainting	☐ Thyroid Problem
☐ Asthma/COPD	☐ Injury to back, arm, or leg	☐ TIA/Stroke
☐ Cancer	☐ Acid Reflux / Heart Burn	☐ Kidney Disease
☐ Other :		
☐ Surgical History *(if applicable)*:		

2. Please list any prescribed medications and doses you are currently taking:

Medication	Dose	Times per day

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3. Please list any over-the-counter medications (including aspirin, dietary supplements, vitamins, minerals, anti-oxidants) you are currently taking:

Medication	Dose	Times per day

4. Do you have any drug/food allergies? ☐ Yes ☐ No

	Allergy	Reaction (what happens)
If yes, please list		

STRESS MANAGEMENT

1. Do you feel that you have an excessive amount of stress in your life? ☐ Yes ☐ No

2. Do you meditate or practice a relaxation technique? ☐ Yes ☐ No
If "yes": Sessions per week: _____ *Minutes per session:* _____

Do you currently do any yoga or tai chi? ☐ Yes ☐ No
If "yes": Sessions per week: _____ *Minutes per session:* _____

3. Have you ever sought counseling? ☐ Yes ☐ No
If "yes", please indicate type of counselor and when: _____
_____

4. Are you currently in treatment with a: ***(please check all that apply)***
☐ Psychiatrist ☐ Psychologist ☐ Social Worker ☐ Therapist ☐ Other Counselor

5. Have you found this counseling/therapy support helpful? ***(please circle a number)***

1	2	3	4	5
Not at all		Somewhat		Very Helpful

PHYSICAL ACTIVITY AND EXERCISE

1. Do currently do any aerobic exercise: ☐ Yes ☐ No
If "yes", how many times per week? _____

2. How long is each exercise session?
☐ Less than 15 min. ☐ 15-30 min. ☐ 31-45 min. ☐ 46-60 min. ☐ More than 60 min.

3. What type of exercise do you usually perform? ☐ Outdoor walking ☐ Treadmill
☐ Jogging ☐ Elliptical ☐ Bicycling ☐ Rowing ☐ Swimming
☐ Other:

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4. **Do you currently do any strength training exercises?** ☐ Yes ☐ No
   If "yes", how many times per week? _____
5. **What type of strength training do you usually perform?**
   ☐ Free weights ☐ Machines ☐ Resistance Bands ☐ Other:
6. **Please list any other hobbies or recreational activities you enjoy:**

NUTRITION

1. **Do you follow a special diet?** ☐ Yes ☐ No
   If "yes", please describe:
2. **Do you have any specific religious or cultural food practices?** ☐ Yes ☐ No
   If "yes", please describe:
3. **Do you have any food allergies or are there foods you are unable to eat?** ☐ Yes ☐ No
   If "yes", please describe:
4. **How would you rate your appetite?** ☐ Good ☐ Fair ☐ Poor
5. **Do you eat when you are not hungry?**
   ☐ Never ☐ Occasionally ☐ Often ☐ Daily
6. **How would you describe your weight over the past year? *(please specify amount)***
   ☐ Gained weight: _____ lbs. ☐ Lost weight: _____lbs. ☐ Weight Unchanged
7. **Have you had any nutritional counseling in the past?** ☐ Yes ☐ No
   If "yes", please describe:
8. **Please describe your alcohol intake** *(1 drink = 5 oz wine, 1.5 oz liquor, 12 oz beer)***:**
   ☐ None ☐ 1-6 drinks/week ☐ 7-13 drinks/week ☐ 14-21 drinks/week
   ☐ More than 21 drinks/week
9. **Have you ever felt that you should cut down on your drinking?** ☐ Yes ☐ No
10. **Have people annoyed you by criticizing your drinking?** ☐ Yes ☐ No
11. **Have you ever felt bad or guilty about your drinking?** ☐ Yes ☐ No
12. **Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hang-over?** ☐ Yes ☐ No

SLEEP

1. **Average number of hours of sleep per night:**
2. **Do you generally feel rested upon awakening?** ☐ Yes ☐ No
3. **Do you nap?** ☐ Yes ☐ No
   If "yes", times per day: _____ *Average duration (minutes):* _____
4. **Do you have problems with insomnia?** ☐ Yes ☐ No
   If "yes", please specify type and frequency: _____
   _____
   _____
5. **Do you have been diagnosed with Sleep Apnea?** ☐ Yes ☐ No
   If "yes", do you use CPAP? ☐ Yes ☐ No

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6. Do you use sleeping aids? ☐ Yes ☐ No
If "yes", please specify type and frequency: _____
_____

OTHER INFORMATION

1. Do you have any hearing difficulty? ☐ Yes ☐ No
If "yes", please specify? _____

2. Do you have any visual problems? ☐ Yes ☐ No
If "yes", please specify? _____

3. Do you have any learning difficulties? ☐ Yes ☐ No
If "yes", please specify? _____

4. How many people live in your household? _____

5. Number of children: _____ *Ages:*_____ *How many at home?* _____

6. Can you count on anyone to provide you with emotional support? ☐ Yes ☐ No

7. Do you have anyone to depend on in an emergency? ☐ Yes ☐ No

8. Do you have a religious orientation or belief system that supports you? ☐ Yes ☐ No

9. Do you feel unsafe or afraid of anyone? ☐ Yes ☐ No

10. Has anyone hurt you, threatened you, or someone that you care about? ☐ Yes ☐ No

11. Have you fallen in the last six months? ☐ Yes ☐ No

CARDIAC REHABILITATION PERSONAL GOALS

1. What are your motivations for enrolling in the Cardiac Rehabilitation Program?

2. What risk factors would you like the Cardiac Rehabilitation team to help you with?
☐ High Blood Pressure ☐ Smoking ☐ Weight ☐ Lack of Exercise
☐ Cholesterol ☐ Stress ☐ Diabetes

3. Do you think there is anything else we should know about you to properly plan your care?
☐ Yes ☐ No *If "yes", please describe:*