UW Medicine
VALLEY
MEDICAL CENTER

CARDIAC REHABILITATION – ADULT HEALTH HISTORY SURVEY

Full Name: _____ Date of Birth: _____
Occupation: _____ Name of Cardiologist_____Last Appt _____
Language spoken at home: ☐ English ☐ Other: _____
Do you have any cultural/spiritual needs that affect your care? ☐ No ☐ Yes – explain: _____
_____

Diagnosis and Date of Procedure _____

MEDICAL HISTORY: (Circle all that apply)

High Blood Pressure	Cancer	Ulcer
Diabetes Type _____	Type _____	MRSA/VRE positive
Stroke	Sleep apnea/CPAP	Kidney disease
Heart Disease/Attack	COPD/Asthma	Liver problems
Seizures, convulsions	Blood clots/Blood Issues	Rheumatic fever
Arthritis/Osteoporosis	Bowel/Bladder Problems	Musculoskeletal Problems
Head injury	Neuromuscular Disease	Pacemaker/Defibrillator
Mental Health Issues	Thyroid Disease	Skin Disease

Any other chronic conditions not mentioned above? _____

Staff Reviewed with Patient _____**Clinician Comments**_____
_____

Other Past Medical History: (please list any surgeries, hospitalizations, serious illnesses or injuries)

DATE	SURGERY/ILLNESS/INJURY	DATE	SURGERY/ILLNESS/INJURY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Symptoms: Have you ever had any of the following conditions? (Please check all that apply.)

☐ Dizziness/Lightheadedness	☐ Insomnia	☐ Excessive coughing	☐ Night sweats
☐ Blood in urine	☐ Anxiety	☐ Frequent heartburn	☐ Severe nausea/Vomiting
☐ Inflamed incision	☐ Frequent headaches	☐ Depression	☐ Weakness
☐ Frequent constipation	☐ Swelling in legs/ankles	☐ Shortness of breath	☐ Joint pain/Back pain
☐ Balance issues	☐ Vision changes	☐ Chest pains	
☐ Irregular heartbeat/Palpitations	☐ Fever/Chills	☐ Unusual weight loss/gain	
☐ Difficulty hearing/seeing	☐ Excessive bruising	☐ Incisional pain	
☐ Excessive skin dryness, pain or itching			

	No	Yes
Do you drink alcohol?	☐	☐ Approximate number of drinks per week? ___Type? _____
Are you a past smoker?	☐	☐ What age did you quit? __How many years did you smoke?___
Do you currently smoke?	☐	☐ How many packs/day? __At what age did you start?____
Do you use recreational drugs?	☐	☐ Type_____

Patient Label

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Current Medications: Please list all prescription and non-prescription medication you are taking.
Please Attach List

MEDICATION	DOSE	REASON	MEDICATION	DOSE	REASON

Allergies: **No** **Yes**
Are you allergic to medication? ☐ ☐ Please list: _____ Reaction: _____

Family History: Have any family members had any of the following? (Please include blood relatives only).

	No	Yes	Relation to You/Age of Occurrence
High cholesterol	☐	☐	
High blood pressure	☐	☐	
Heart disease	☐	☐	
Stroke	☐	☐	
Diabetes	☐	☐	
Other cancer	☐	☐	
Osteoporosis	☐	☐	
Clotting disorder	☐	☐	

Other diseases that may run in your family (migraines, thyroid condition, arthritis, etc.): _

Decision Authority Transfer: **No** **Yes**
Do you have an advance directive or living will? ☐ ☐ Location: _____
Do you have a durable power of attorney for healthcare? ☐ ☐

Stress Management:
In general, how would you rate your stress? (scale 1- low 10- high)_____
What techniques do you use to manage your stress?_____

Daily Living/Physical Activity/Assistive Device:
Support / Live (with): Alone Spouse Friend Family
Do you use a walker, cane, rolling walker? (Circle all that apply)

Exercise History:
How many minutes are you able to walk without stopping?____ How often do you exercise a week?___
Type of exercise or activity_____

Patient Signature_____ **Date**:_____

Additional Comments

Patient Label