UCLA Health System

Cardiopulmonary Rehabilitation Department

CARDIAC REHABILITATION PROGRAM
Patient Health Assessment Questionnaire

In order to prescribe the proper rehabilitation program to suit your individualized needs, please fill out the following questionnaire regarding your health.

Name: _____
(Last) (First) (Initial)

Address: _____
(Street Address)

_____
(City) (State) (Zip)

Date of Birth: _____ Age: _____ Email Address: _____

Emergency Contact Name & Phone: _____

Referring Physician & Phone: _____

Primary Physician & Phone: _____

Insurance: _____ Co-payment amount: _____ *(Due on date of service)*

Please briefly state, in your own words, why you were referred to this program: _____

_____

Medications: Please list all prescribed *and* over-the-counter medications that you take. Please include the dose and number of times per day (or attach your already-prepared list).

Name	Dose	How Often?	Name	Dose	How Often?

Allergies: _____

Do you have an Advanced Directive or Durable Power of Attorney? _____

If Yes, please provide a copy to the Cardiac Rehab Clinician. If no, do you wish to receive information? Yes / No

Do you have any cultural, spiritual, or religious beliefs that might affect how we teach you? _____

UCLA Health System

Cardiopulmonary Rehabilitation Department

REVIEW OF SYSTEMS	**YES**	**NO**	**NOT SURE/Comments**
Pl*ease make a check in the correct box and Please explain any "yes" in Comment Section*			
HAVE YOU EVER HAD?			
High blood pressure			
High Cholesterol			
Heart attack			
Abnormal EKG			
Chest pain or Angina			
Heart valve problem			
Irregular heart beat or palpitations			
"Fluid on the lungs"-Congestive heart failure			
Swelling of ankles			
"Balloon Procedure" or stent-Angioplasty			
Pain in leg(s) when walking or active			
Pacemaker or defibrillator			
Anemia			
Pain or cramping in your legs when you walk			
Recent cough,cold,fever,chills in the last 2 weeks			
Asthma			
Pneumonia in the last 2 months			
Emphysema			
Shortness of breath when lying down? How many pillows do you use?			
Use Oxygen at home? How many liters?			
Loud snoring or Sleep Apnea			
Use CPAP or BIPAP machine			
Pulmonary embolism(blood clot in lungs)			
Other lung or breathing problem			
Kidney failure/Hemodialysis/Peritoneal Dialysis			
Liver disease, cirrhosis			
Hepatitis or jaundice			
Transplant of Kidney/Liver/Pancreas			
Heartburn, acid reflux			
Difficulty swallowing or choking on food/drink			
Take diet medications now or in the past			
Recent weight loss of 20 lbs or more due to illness			
Ulcerative colitis? Last steroid use?			
Muscle disease			
Stroke or TIA ("mini-stroke")			
Seizures or Convulsions			
Have you fallen recently? Please explain.			

UCLA Health System

Cardiopulmonary Rehabilitation Department

Do you have pain? Where?			
Does your pain increase with activity?			
Do you use an assist device? (e.g. walker, cane, etc)			
	YES	**NO**	**NOT SURE/Comments**
Diabetes			
If diabetic-how long?			
Range of morning glucose from low to high			
Insulin?			
Oral medication for diabetes?			
Current or past smoker			
How many packs per day?			
How many years?			
If you quit, when was your quit date?			
If you have not, are you willing to quit?			
Exercise			
What type (swim, bike, walk, etc)			
How many days per week?			
How long is each exercise session?			
Would you call your exercise light, moderate, or strenuous?			

SURGERIES:

YEAR	Surgery	WHERE
1		
2		
3		
4		

What activity of daily living can you no longer perform due to your cardiac disease?

_____

What do you hope to achieve from this Cardiac Rehab Program?

_____

Declaration of Commitment:

I, _____, am willing and motivated to enter UCLA's Cardiac Rehabilitation Program, and that I am ready to receive health instruction at this time. This program will include 3 days per week of supervised exercise and Cardiac-related education, which will help me to better manage my heart condition. I am also committed to following the recommended prescribed home exercise program given to me by the Cardiac Rehabilitation clinician. Finally, I am committed to maintain a non-smoking status, or, if I am a smoker, I will accept smoking cessation counseling and commit to quitting by the 3rd rehabilitation session.

Signature _____ Date _____