



P.O. Box 153178, Tampa, FL 33684
 Health and Wellness Material

Congestive Heart Failure Assessment Form

Date:
 Member Name:
 Member Address:
 City State Zip:

Date of Birth:
 Phone#:

ID#:

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? Yes No

If you received this form in error and don't have this health, check the box and return the form to us in the supplied envelope without answering any of the questions below. No, I don't have Congestive Heart Failure.

1. Do you experience shortness of breath? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
2. Do you get tired or short of breath when walking? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
3. Do you have swelling in your feet, ankles, or legs? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. If you answered yes to #3, how deep a print does it leave? (check one) <input type="checkbox"/> ¼ inch <input type="checkbox"/> ½ inch <input type="checkbox"/> More than ½" <input type="checkbox"/> None
5. Do you experience abdominal pain or swelling? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always
6. Does your Blood Pressure usually run higher than 140/90? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
7. Do you weigh yourself daily? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, do you have access to a scale? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. How much does your weight change in a week? (check one) <input type="checkbox"/> 1 lb. <input type="checkbox"/> 2 lbs. <input type="checkbox"/> 3-4lbs. <input type="checkbox"/> More than 4 lbs.
9. Do you take a Diuretic? (i.e: water pill) (check one) <input type="checkbox"/> Once a day <input type="checkbox"/> Twice a day <input type="checkbox"/> More than twice a day <input type="checkbox"/> None

Congestive Heart Failure Assessment Form *(continued)*

10. How often in the past year have you been to the Emergency Room due to your Congestive Heart Failure (CHF)?
 (check one) 0 1 time 2-3 times More than 3 times

11. How often in the past year have you been hospitalized due to your CHF?
 (check one) 0 1 time 2-3 times More than 3 times

12. What type of diet do you follow?
 (check all that apply) Low Salt Low Fat High Potassium High Fiber No specific diet

13. Do you smoke? Yes No

14. Do you use Oxygen at home? Yes No
 If yes: 1-2 liters 3-4 liters > 4 liters

15. How often have you seen your PCP in the last 6 months?
 (check one) 0 1 time 2 times 3-4 times More than 4 times

16. How often have you seen your Cardiologist in the last year?
 (check one) 0 1 time 2 times 3-4 times More than 4 times

17. Does your Congestive Heart Failure interfere with your daily activities?
 (check one) Never Rarely Sometimes Very Often Always

18. Do you think your Congestive Heart Failure has become better or worse over the past year?
 (check one) Better Worse Stayed the same

19. Who treats you for your Congestive Heart Failure?
 (check all that apply) PCP Cardiologist Other

20. How would you rate your ability to take care of yourself with the support you have in place?
 (check one) Excellent Good Fair Poor