# Cardiovascular Assessment Form

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

Date: ______________________ Date of Birth: ______________

Member Name: ______________________ Phone#: ______________

Member Address: ______________________

City State Zip: ______________________ 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 Coronary Artery Disease.**

**1. Do you experience shortness of breath?** ❑ Yes ❑ No
**If yes, then how often do you get short of breath?**
(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**2. Do you experience chest pain?** ❑ Yes ❑ No
**If yes, how often do you have chest pain?**
(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**3. Do you have swelling in your feet, ankles, or legs?** ❑ Yes ❑ No
**If yes, then how often do your feet, ankle or legs swell?**
(check one) ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**4. Have you ever had a Heart Attack?**
(check one) ❑ Yes ❑ No

**5. If yes, how long ago was your Heart Attack?**
(check one) ❑ Less than 1 year ❑ 2-3 years ago ❑ More than 3 years ago

**6. Have you ever had heart surgeries, ex. bypass, stents?** ❑ Yes ❑ No

**7. Does your Blood Pressure usually run higher than 140/90?**
(check one) ❑ Yes ❑ No ❑ Don't Know

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# Cardiovascular Assessment Form *(continued)*

**8. Do you have any of the following?** (check all that apply)
❑ High Cholesterol ❑ Diabetes ❑ Problems with circulation in your legs

**9. What type of diet do you follow?**
(check one) ❑ Low Salt ❑ Low Fat ❑ Heart Healthy ❑ No specific die

**10. Do you use tobacco (smoke, chew, snuff, vape or in any other form)?** ❑ Yes ❑ No

**11. Do you use Oxygen at home?** ❑ Yes ❑ No

**12. How often do you exercise per week?**
(check one) ❑ 1-2 days ❑ 3-4 days ❑ 5-7 days ❑ Don't exercise regularly

**13. Does your heart condition prevent you from enjoying your life?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**14. How often have you seen your PCP in the last year for your heart condition?**
(check one) ❑ 0 ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ More than 4 times

**15. 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

**16. How often in the past year have you been to the Emergency Room due to your heart condition?**
(check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times

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

**18. Do you think your heart condition has become better or worse over the past year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

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