Questionnaire to help set goals and improve heart care

CardioSmart
AMERICAN COLLEGE of CARDIOLOGY

Preparing for your visit | Long form

Name: _____

Date: _____/_____/_____

Fill out this form. Your answers will help us make sure your treatment aligns with your goals and takes into account your concerns.

Goals for your visit

1. What do you **most want to accomplish** during this visit? (Are there questions you would like answered?)

_____

_____

_____

2. Is there **anything that is bothering or concerning you** that, if addressed, would help you feel better?

_____

_____

_____

Do you have questions about or issues with:

(Please check all that apply and explain briefly. Circle any areas that you would like to be sure we discuss.)

❑ Understanding your heart disease and the related risks or possible complications

❑ Medications (cost, side effects, difficulty remembering to take them, not knowing how they help you)

❑ Exercise or ways to stay active

❑ Heart-healthy eating habits

❑ Tobacco use or exposure to other people's tobacco smoke or other products

❑ Physical strength and balance (any recent falls, not keeping up with peers)

❑ Coping and emotional well-being (if you feel very stressed, or unusually sad or down)

❑ Managing other health conditions (for example, diabetes, kidney disease, arthritis)

❑ Memory problems

❑ Disrupted sleep or snoring

❑ Keeping or being able to get to health visits

❑ Support from family, friends, or peers for you or your caregiver

❑ Money worries (having a hard time paying for food, rent or mortgage, utilities, medicines, health care)

❑ Other:

Overall, since your last visit, would you say that you feel:

❑ Better

❑ Worse

❑ About the same

❑ Different – in what way(s)? _____

How often did you follow your care plan in the past month (for example, with lifestyle changes, taking medicines or other recommendations)?

- ❑ Always
- ❑ Usually
- ❑ Sometimes
- ❑ Rarely
- ❑ Never

What makes it hard for you to stick with your care plan?

_____

_____

Would you like more information about or do you think you could benefit from:

- ❑ Physical therapy, strengthening
- ❑ Walking assistance
- ❑ Cardiac rehabilitation
- ❑ Nutrition
- ❑ Other symptoms:

  _____

  _____

Do you track any of the following measures at home? If yes, with what? _____

- ❑ Blood pressure
- ❑ Heart rate
- ❑ Blood sugar
- ❑ Daily weight
- ❑ Other: _____

What other health conditions do you have?

- ❑ Angina (chest pain or discomfort)
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Being overweight or obese
- ❑ Heart failure
- ❑ Atrial fibrillation or other heart rhythm problem _____
- ❑ Heart valve disease (when one or more of the valves in the heart don't work properly)
- ❑ Depression or anxiety
- ❑ Thyroid disease (either having too much or too little thyroid hormone)
- ❑ Chronic kidney disease
- ❑ Sleep apnea
- ❑ High blood pressure during pregnancy (preeclampsia)
- ❑ Previous or existing cancer _____
- ❑ Memory problems or dementia
- ❑ Autoimmune disorders (for example, lupus, rheumatoid arthritis, multiple sclerosis, Crohn's disease or colitis) _____
- ❑ Musculoskeletal conditions (for example, arthritis or carpal tunnel syndrome) _____
- ❑ High use of alcohol (more than 1 drink a day for women, more than 2 drinks a day for men) or other substance abuse
- ❑ Current or previous tobacco use
- ❑ Other: _____

As you complete the rest of this worksheet, please circle or star any areas you would like to be sure we discuss. This will help us better meet your goals and identify areas where we can give you more information or support.

How heart disease affects what you can do – check-in

Use this chart to let us know how your heart disease (or other health conditions) limits what you can do.

Does it limit your ability to:	Not at all	Some-times	Often	Most of the time	All the time
Work (being able to meet job responsibilities or tasks)	❑	❑	❑	❑	❑
Shower or bathe	❑	❑	❑	❑	❑
Dress yourself	❑	❑	❑	❑	❑
Walk short distances (around the block or up a flight of stairs)	❑	❑	❑	❑	❑
Get up easily from a chair or out of bed	❑	❑	❑	❑	❑
Prepare or cook a meal	❑	❑	❑	❑	❑
Do housework, cleaning	❑	❑	❑	❑	❑
Take part in hobbies, recreational activities	❑	❑	❑	❑	❑
Be social (attend get togethers, stay connected)	❑	❑	❑	❑	❑
Go out for a meal or other activity	❑	❑	❑	❑	❑
Stay emotionally healthy (overall, feeling happy, fulfilled and having healthy ways to deal with stress)	❑	❑	❑	❑	❑
Think clearly, concentrate	❑	❑	❑	❑	❑
Be physically intimate	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Travel	❑	❑	❑	❑	❑

Anything else that you are unable to do or have a hard time doing because of your health?

Emotional well-being and coping – check-in

When you think about having heart disease, how does it make you feel?

_____

_____

Overall, how well are you coping with heart disease and other conditions?

Very poorly	Poorly	OK	Fairly well	Very well, all things considered

On a scale from 0 to 10, how stressed or anxious have you been feeling?

Not at all stressed or anxious — *The most stressed or anxious I've ever felt*

0	1	2	3	4	5	6	7	8	9	10

What sources of stress in your life might be interfering with your health or ability to follow treatment recommendations (for example, work, job loss, death in the family, childcare)?

_____

_____

On a scale from 0 to 10, how sad or depressed have you been feeling?

Not sad at all — *The worst sadness I've felt, nothing cheers me up*

0	1	2	3	4	5	6	7	8	9	10

In the past 2 weeks, have you had less interest or pleasure in doing things that usually bring you joy, or have you been feeling hopeless or very sad?

- ❑ Yes
- ❑ No

Have you shared these feelings with anyone?

- ❑ Yes
- ❑ No

If no, why not? _____

Medications – check-in

Do you have any concerns with any of your medications? ❑ Yes ❑ No

If yes, please explain:

_____

_____

In a typical week, how often do you miss a dose of your medication?

Never miss a dose	Once or twice	A few times	Nearly every day

What do you think contributes to you missing doses?

_____

_____

Use this chart to let us know how you manage other challenges you might have with your medications.

	Yes	No	Please explain.
Do you use a pillbox, alarm or other way to remind you to take your medicines?	❑	❑	
Do you have trouble getting your medications filled?	❑	❑	
Do you have difficulty paying for any of your medications?	❑	❑	

Lifestyle – check-in

Answer these questions to let us know how physically active you are, your efforts to eat a heart-healthy diet, and if you use tobacco.

Physical activity and exercise

Do you have a regular physical activity or exercise routine? ❑ Yes ❑ No

What types of activities do you do for exercise or physical activity?
(Circle the activity you enjoy the most.)

_____

_____

_____

How many days of the week are you physically active?

1	2	3	4	5	6	7

How long do you usually exercise (per session of activity)? (Please circle)

Less than 30 minutes	30 minutes	30-60 minutes	60 minutes or more

Would you like to be more active? ❑ Yes ❑ No

Are there things that make it hard for you to exercise or be physically active?
(For example, shortness of breath, fatigue, pain, joint or back issues, lack of time, no safe place to exercise, fear, or feeling unsure about how to start or what to do.)

_____

_____

_____

If you've had a recent heart attack, had stent(s) placed or underwent heart surgery, were you offered cardiac rehab? ☐ Yes ☐ No

If so, did you participate? ☐ Yes ☐ No

What is your personal goal when it comes to physical activity and your heart health?

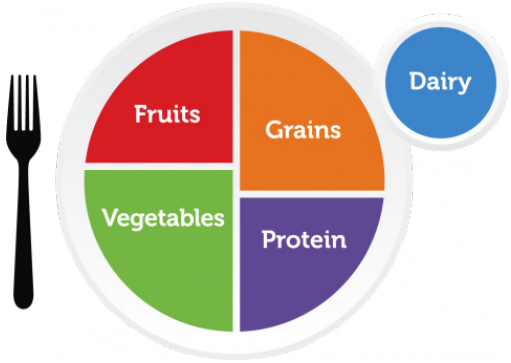
_____

_____

Heart-healthy eating, nutrition

What are some of the things you do to eat a heart-healthy diet? (Please check all that apply.)

- ☐ Limit salt (sodium) intake
- ☐ Pay attention to calories
- ☐ Read food labels (for added sugars, salt, fats)
- ☐ Pick lean meats (tenderloins, skinless chicken, etc.)
- ☐ Limit, or not eat, deli or processed meats
- ☐ Use the plate method (shown below) to choose foods and portions



- ☐ Eat more vegetables
- ☐ Eat 1-2 servings of fish a week
- ☐ Bake, broil or grill instead of fry foods
- ☐ Use olive oil or vegetable oil instead of butter
- ☐ Cut back on sweets or desserts
- ☐ Follow a plant-based diet, the Mediterranean diet or other eating program

  _____
- ☐ Other: _____

To learn more, visit www.MyPlate.gov.

How many servings of these foods do you eat each day? (A serving size is a standard amount of food, such as a cup or an ounce, or what is noted on food packaging.)

Fresh fruits _____

Fresh vegetables _____

Whole grains (whole-wheat breads or pasta, bran, barley, oatmeal, brown rice) _____

How often do you eat out or buy already prepared meals?

Never	Sometimes (a few times a month)	Once a week	Several times a week

What are your favorite foods to snack on?

1. _____

2. _____

3. _____

How many alcoholic beverages do you drink each week? _____

How many sugar-sweetened beverages do you drink each week (juices, soda, coffee creamers)? _____

Do you think you are at a healthy weight or would you like to lose weight?

- ❑ I'm happy with my weight.
- ❑ I'd like to lose weight.
- ❑ I'd like advice on how to maintain or not gain weight.

What is your personal goal when it comes to your diet?

_____

_____

Tobacco use and your heart

Do you use tobacco (any product, including vaping)? ❑ Yes ❑ Never

If yes, how often?

Every day	Most days of the week	Several times a week	A few times a month	Only a few times a year

Are you around other people who smoke at work or at home? ❑ Yes ❑ Never

If yes, how often?

Every day	Most days of the week	Several times a week	A few times a month	Only a few times a year

If you use tobacco:

1. Have you tried to stop using tobacco before? ❑ Yes ❑ No
   If yes, what have you tried?

   _____

   _____

2. Have you been offered help to stop using tobacco? ❑ Yes ❑ No
3. Are you ready to try to quit? ❑ Yes ❑ No

Social needs – check-in

Your health is influenced by where you live, work and play. There may be resources we can connect you with to help. Please take the time to answer these questions honestly.

Do you have a hard time getting to or from health visits, lab or imaging tests?	❑ Yes	❑ No
Do you live alone? If no, who lives with you: _____	❑ Yes	❑ No
Do you have someone you feel close to and can rely on if you need help?	❑ Yes	❑ No
Do you worry that you won't be able to pay for: • Food • Rent or mortgage • Gas or electricity • Childcare • Insurance • Other (explain): _____	❑ Yes ❑ Yes ❑ Yes ❑ Yes ❑ Yes	❑ No ❑ No ❑ No ❑ No ❑ No
Do you have trouble paying for your medical care or medications?	❑ Yes	❑ No
Do you work?	❑ Yes	❑ No
Do you worry about job security or taking time off due to your health?	❑ Yes	❑ No
Are you able to buy fresh fruits, vegetables and other healthy foods easily?	❑ Yes	❑ No
Do you have a safe place to walk or get exercise?	❑ Yes	❑ No

How confident are you that you understand what atherosclerotic cardiovascular disease (ASCVD) is and what it means for your health?

Not at all *Very*

0	1	2	3	4	5	6	7	8	9	10

How confident are you that you know what to do to manage your heart health and prevent a stroke, heart attack, or other health condition?

Not at all										*Very*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

If you circled 0-6, what would help you feel more able?

Do you know where to go to get more information or support? ❑ Yes ❑ No

How confident are you that you understand the recommendations for exercise, diet, medications?

Not at all										*Very*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Do you have any other concerns not mentioned above?

Thank you for taking the time to complete this survey.