Questionnaire to help set goals and improve heart care

CardioSmart
AMERICAN COLLEGE of CARDIOLOGY®

Preparing for your visit | Short 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

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

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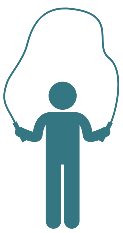

☐ Exercise or ways to stay active

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____

☐ Heart-healthy eating habits

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____

☐ Tobacco use or exposure to other people’s tobacco smoke or other products

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____

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

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____

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

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

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____

☐ 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?

____

____

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

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

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

- ☐ Physical therapy, strengthening
- ☐ Walking assistance
- ☐ Cardiac rehabilitation
- ☐ Nutrition
- ☐ Other symptoms:
- ☐ Coping, mental health support
- ☐ Stopping tobacco use
- ☐ When to call or check in

____

____

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: ____

Thank you for taking the time to complete this form.