389 Fort Salonga Road
Northport, NY 11768
Phone: 631-686-6658
Fax: 631-651-8959

QUALITY MEDICAL FITNESS
Cardiopulmonary Rehabilitation Department

CARDIAC REHABILITATION PROGRAM

Patient Health Assessment Questionnaire

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

Name: _____
(last) (first) (initial)

Address:
_____
(Street Address)
_____
(City) (State) (Zip)

Home Phone: _____ Cell Phone: _____
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 indicate the dose and number of times per day (or attach your already prepared list).

Name	Dose	How Often?	Name	Dose	How Often?

Allergies:
_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?	**YES**	**NO**
Breathless with strenuous exercise		
Short of breath when hurrying on the level or walking up a slight hill		
Walks slower than people of the same age on level ground because of breathlessness, or has to stop for breath when walking at own pace on level ground		
Stops for breath after walking about 100 yards or after a few minutes on level ground		
Too breathless to leave the house or when dressing or undressing		

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REVIEW OF SYSTEMS	YES	NO	NOT SURE/COMMENTS
Please make a check in the correct box and Please explain any "yes" in comment section			
HAVE YOU EVER HAD?			
High blood pressure			
Heart attack			
Abnormal EKG			
Chest pain or angina			
Heart valve problem			
Irregular heart beat or palpitations			
"Fluid in 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			
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 the 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 20lbs or more due to illness			
Ulcerative colitis? Last steroid use?			
Muscle disease			
Stroke or TIA ("mini-stroke")			
Seizures or convulsions			
Hospitalizations in the last year?			
Flu vaccine			
Pneumonia vaccine			
Do you use an assistive device? (e.g. walker, cane, etc.)			
Have you fallen recently? Please explain.			

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REVIEW OF SYSTEMS	YES	NO	NOT SURE/COMMENTS
Do you have pain? Where?			
Does your pain increase with activity?			
Diabetes			
If diabetic, how long?			
Range of morning glucose from low to high			
Insulin?			
Oral medications 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 pulmonary disease?

_____

What do you hope to achieve from this pulmonary program?

_____

Do you have an Advance Directive or Durable Power of Attorney for Healthcare? Y/N. If yes, is a copy in the system? Y/N.

If no, please provide a copy. If no to the first question, would you like to receive information? _____

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

_____

Declaration of Commitment:

I, _____, am willing and motivated to enter Quality Medical Fitness P.C.'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 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: _____**

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QUALITY MEDICAL FITNESS

CARDIOPULMONARY REHABILITATION

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling asleep, staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**
COLUMN TOTALS:		**____ +**	**____ +**	**_____**
ADD TOTALS TOGETHER: _____				

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

□ **Not difficult at all**	□ **Somewhat difficult**	□ **Very difficult**	□ **Extremely difficult**

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Medication /Allergy History:	
Allergies/Sensitivities (drugs, herbs, foods, dye, latex, tape, etc.)	**Reaction:**

PATIENT MEDICATION RECORD

Medication/Drug	Dose	Route	Frequency	Reason

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Name: _____

Date: _____

The Generalized Anxiety Disorder 7 – Item Scale

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about difference things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: ☐ **=** **Add Columns** _____ + _____ + _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
_____	_____	_____	_____

Interpreting the Score:

Total Score	**Interpretation**
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild anxiety
10	Moderate anxiety
15	Severe anxiety

Privacy Officer
Quality Medical Fitness

Acknowledgment

By signing below, I acknowledge that I have been provided a copy of the Practice's Notice of Privacy Practices (the "Notice") and have therefore been advised of how health information about me may be used and disclosed by the Practice and how I may obtain access to an control this information. I also acknowledge that the practice may use and disclose my health information to treat me and arrange for my medical care, to seek, and receive payment for services given to me, and for the business operations of the practice, its staff.

_____ _____

Signature of patient or
Patient's representative

Date

_____

PRINT NAME