Chattanooga LIFESTYLE CENTER

CARDIAC REHABILITATION

Admission Application and Medical History

PATIENT: ______________________ Today's Date: __________

Address: ______________________ City: __________

Home Phone: ______________________ Cell Phone: __________

Date of Birth: __________ Age: __________ Height: __________ Weight: __________

Marital Status: Married Single Divorced Widowed

Hospital Preference: ______________________

Primary Care Physician: ______________________ Cardiologist: __________

Highest level of education: ______________________ Preferred spoken language: __________

EMERGENCY CONTACT: ______________________ Relationship: __________

Home Phone: ______________________ Cell Phone: __________

EMPLOYER: ______________________ Phone: __________

Occupation (current/most recent): ______________________

Current Work Status: Full Time Disabled Part Time Self-Employed Unemployed Retired

Other: __________ Retirement Date: __________

How do you learn best? (Circle one): Seeing Hearing Doing No Preference

DIAGNOSIS HISTORY: (Indicate date of diagnosis or surgery)

Heart Attack __________ Coronary Artery Bypass __________ Pacemaker/Defibillator __________

Stent/PCI __________ Congestive Heart Failure __________ Angina/chest Pain __________

Heart Valve Surgery __________

MEDICATIONS: (List all prescribed medications currently taking. Use separate sheet or attach list, if necessary)

______________________ ______________________

______________________ ______________________

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______________________ ______________________

ALLERGIES: (Medication or food) ______________________

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ADDITIONAL MEDICAL ISSUES: (If you had any of the following medical conditions, please indicate date of diagnosis.)

Condition	Date	Condition	Date
Abnormal EKG	____________	Hypoglycemia	____________
Anemia	____________	Irregular Heartbeat	____________
Arthritis	____________	Kidney Disease	____________
Blood Clots	____________	Lung Disease	____________
Cancer	____________	Obesity	____________
Depression/Anxiety	____________	Orthopedic Disorder	____________
Diabetes	____________	Perpheral Vascular Disease	____________
Enlarged Heart	____________	Psychiatric Disorder	____________
Eye trouble	____________	Pulmonary Embolus	____________
Frequent Headaches	____________	Rheumatic Fever	____________
GI Problems	____________	Stroke	____________
Gout	____________	Thyroid Disorder	____________
Heart Murmer	____________	Ulcer	____________
High Blood Pressure	____________	Varicose Veins	____________
Hyperglycemia	____________		

Have you experienced any emotional or physical abuse in the past or present? Yes No

If yes, are you interested in referral information? Yes No

RECENT HOSPITALIZATION/SURGERIES:

Date:	Reason:
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________

FAMILY MEDICAL HISTORY: (Enter immediate family member's relationship)

Heart Attack: ____________________ Stroke: ____________________

High Blood Pressure: ____________________ Diabetes ____________________

ALCOHOLIC BEVERAGES: Do you consume Alcohol? Yes No

If yes, type: __________ How many drinks per day? _____ How many days per week? _____

SMOKING: Do you currently smoke? Yes No

If Yes, how many per day? Cigarettes: _____ Cigars: ______ Pipe: _____

If No, have you smoked in the past? Yes No

If Yes, When? _________ Quit date: _________

Are you currently using nicotine gum, patches or other stop-smoking aids? ____________

EXERCISE: Are you currently exercising? Yes No

If Yes, indicate activity and duration: ______________________________

If No, were you active in the past? Yes No

If Yes,specify activity: ______________________________

COMMUNITY SUPPORT: Do you have family or friends in the home or community to help you with needs; such as driving or meal preparation? Yes No