CORONARY ARTERY DISEASE LIFESTYLE EVALUATION

Patient Name:_______________________     Date:_________

Physician’s Name:___________________________________

If you are a patient with documented Coronary Artery Disease, i.e. history of angina, prior heart attack, coronary angioplasty, stent of coronary artery bypass surgery, please answer the following questions to assist us in caring for you.

Have you ever had angioplasty? □ YES □ NO
   If yes, when: __________________________

Have you ever had bypass surgery? □ YES □ NO
   If yes, when: __________________________

Do you get chest pain, angina, shortness of breath or fatigue with mild to moderate activity, i.e.; walking 1 or 2 blocks, walking uphill, climbing one flight of stairs or walking fast? □ YES □ NO

Do you feel that you are limited in your ability to do simple activities of daily living such as cleaning, house chores, shopping or leisure? □ YES □ NO

Do you ever get angina of shortness of breath at rest, after eating, or just watching television. □ YES □ NO

Do you ever awaken at night with chest pain, discomfort or shortness of breath? □ YES □ NO

Do you take Nitroglycerin tablets before certain activities? □ YES □ NO

Have you lessened your activity in the past 6 months or so due to chest discomfort or shortness of breath? □ YES □ NO

Are you dissatisfied with your current quality of life because of a lack of energy, symptoms or inability to exercise much (excluding orthopedic problems)? □ YES □ NO

Please return survey to the technician or nurse bringing you to see your physician.