

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
Fatigued 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.