Cardiac Rehabilitation

McLaren Greater Lansing

Program Admission Form

Name:	Age:	Date of Birth:
Address (street, city, zip):		
Phone Number:		SS #:
Cardiac incident preceding rehab: (Circle one) Angina Heart Attack Bypass Surgery Other Date of above incident: Angioplasty Stent Placement Valve Surgery		
Emergency Contact: Relationship:	Phone:	

Cardiologist: Date of last visit: Date of next scheduled visit:	Primary Care Physician: Date of last visit: Date of next scheduled visit:

Health History

Do you now have or have ever had any of the following? Check YES or NO

	Y	N		Y	N
1. Chest Pain / discomfort / pressure / angina			14. Asthma / bronchitis / emphysema		
2. Heart Attack			15. Stop breathing when asleep (apnea)		
3. Irregular heart beat / palpitations			16. Seizures		
4. Shortness of breath with or without activity			17. Dizziness / fainting / falling		
5. Rheumatic Fever / heart murmur			18. Thyroid problems		
6. Stroke			19. Fatigue		
7. Leg cramps / poor circulation in the legs			20. Anxiety / depression		
8. Congestive Heart Failure			21. Joint pain / arthritis		
9. Swelling of hands, ankles, feet			22. Back / neck pain or problems		
10. High or Low blood pressure			23. High cholesterol		
11. High or Low blood sugar			24. Blood clots		
12. Pacemaker or defibrillator			25. High daily stress		
13. Renal problems			26. Other (cancer, skin disease, etc.)		

List previous surgeries, hospitalizations, or other medical conditions.

1.	4.
2.	5.
3.	6.

Exercise Physiologist to review "yes" answers and document below.

Staff Signature: _____

Date: _____

Medication	Dosage	Frequency	Prescribed by	Changes / Date

Are you allergic to any medications? Yes No List:

Are you on a cholesterol lowering drug? Yes No Date started:

Do you have a family history of heart problems? Yes No Who:

Do you smoke (now or in the past)? Yes No If yes, how much? If quit, when?
Have you received smoking cessation education? Yes No Refused

Last Stress Test: Date: Location:
Next Stress Test: Date: Location:

Employment Status before recent heart problem: Full Time Part Time Retired Other
Primary job description: Expected return to work date:

Does your Insurance cover: Phase 2? Yes No Phase 3? Yes No
Please elaborate on any limitations:

Activity level **prior** to your heart event:
Regular exercise at least 3 times/week.
Some exercise, but not regularly.
Rarely or never exercised.

Do you suffer from depression? Yes No Onset date:
Have you discussed this with your doctor? Yes No
Have you been referred for counseling? Yes No Refused

Heart Attack and Healing
Heart Arteries - Normal / Abnormal
Congestive Heart Failure / Cardiomyopathy
Bypass Graft Surgery
Stent / Angioplasty
Emergency Plan for Home
Your Medications
How to Take Your Pulse
High Blood Pressure
Stress and Your Heart
Smoking and Your Heart
Return to Work Questions
Eating for a Healthy Heart
Guidelines for Activity at Home
Emotional Changes After Heart Problems
High Cholesterol
Sexual Activity and Your Heart
Weight Loss

Staff Signature: Date: