

Client Name: Date:

Assessment for Healthy Heart Program

Cardiac Procedure or Condition: _____

Do you have or had any of the following medical conditions?

Atrial Fibrillation Asthma Epilepsy Stroke - year ____

Wound infection (after heart surgery) Angina

Joint problems _____

Back problems _____ Respiratory disease _____

Any other problems _____

Medications: _____

Quality of Life

In general would you say your health is:

Excellent Very Good Good Poor Very Poor

What would you like your health to be?

Excellent Very Good Good Poor Very Poor

Compared to one year ago, how would you rate your health now?

Much Better A Little Better Same A Little Worse Much Worse

During the Past Three weeks, has the state of your physical or emotional health interfered with your normal activities?

Not at all Slightly Moderately Quite a bit Extremely

What are your plans or current routine for physical activity?

Do you believe you require a carer? Yes / No

Do you have a carer? Yes / No



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