

Cardiac Rehabilitation Centre (CRC) Initial Patient Questionnaire

Please complete the following questionnaire and return it by email or by mail in the enclosed postage marked envelope. Print clearly and place check marks in the boxes where appropriate.

****All fields must be completed****

Date questionnaire was completed (yyyy/mm/dd): _____

Personal Information

Title: _____ First name: _____ Last name: _____

(Mr./Mrs./Ms./Dr./Prof.)

Preferred name: _____ Date of birth (yyyy/mm/dd): _____

Address: _____

City: _____ Postal Code: _____

Telephone number: (check box of preferred daytime number)

Home: _____ Work: _____ Cell: _____

E-mail: _____

Emergency Contact Person: _____

Relationship: Spouse/Partner Parent Child Other: _____

Telephone number: _____

Marital Status: Single Married/Common law Divorced/Separated Widowed

Primary Care Provider: Family Doctor Nurse Practitioner None

Name: _____

Address: _____

Telephone number: _____

Do you have a cardiologist? No Yes (please provide name): _____

Language Spoken

English French Other: _____

If you need an interpreter, please specify what language: _____

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Special Needs & Considerations

Check any of the following impairments or difficulties that you may have:

- Visual impairment Hearing impairment Physical impairment Difficulty reading
 Difficulty writing Difficulty understanding some things Other: _____

Social Information

- Do you live: Alone With Other(s): _____
- Do you have children? No Yes: number: ____ proximity to you: _____
- Do you drive? Yes No (indicate means of transportation): _____
- What type of dwelling do you live in: House Apartment Condo Other: _____
- Do you have to climb stairs? No Yes; if yes, how many? _____
- List any environmental safety concerns at home: _____

Employment

- Occupation (current or former if retired): _____
- Occupational Status: Full Time Part Time Student Self Employed Unemployed
 Retired Long Term Disability Short Term Disability
- What are your usual hours and days of work? Hours (shifts): _____ Days: _____
- Do you work shift work? No Yes
- If yes, what shifts (check all that apply)? Days Evenings Nights
- If you are currently off work due to your cardiac condition, please indicate your expected return to work date, if known (yyyy/mm/dd): _____
- Expected activity levels on return to work: Sedentary Light Moderate Heavy
- Income sources:
- Employment Pension Ontario Works (OW) Ontario Disability Support Program (ODSP)
 Canada Pension Plan (CPP) Long Term Disability (LTD)
- Other: _____

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Medical History

Check all of the conditions you have been diagnosed with and provide comments for each.

Cardiovascular History	Response	Year Diagnosed	Comments
Heart attack	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Irregular heartbeat (arrhythmia)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Valve problems/murmurs	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Angina/chest pain/tightness	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Heart failure	<input type="checkbox"/> No <input type="checkbox"/> Yes		
High cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Peripheral Arterial/Vascular Disease (poor circulation in legs)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Transient Ischemic Attack (TIA or 'mini stroke')	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Pulmonary embolus (PE, blood clot in lungs) or deep vein thrombosis (DVT)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Other (list here):			

Other Medical Conditions	Response	Year diagnosed	Comments
Seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Multiple Sclerosis	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Parkinson's Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Neuropathy	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Kidney dysfunction or failure	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Gout	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Chronic fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Lupus Erythematosus	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Hypothyroidism	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Heartburn/reflux	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Hernia	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Erectile dysfunction	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Eye problems	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Alzheimer's disease or dementia	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Other memory impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes		

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Respiratory System	Response	Year Diagnosed	Comments
Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes		When was your last asthma attack? yyyy/mm: _____
Emphysema/ Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Pulmonary Fibrosis	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Sleep Apnea	<input type="checkbox"/> No <input type="checkbox"/> Yes		Continuous Positive Airway Pressure (CPAP) Are you using CPAP? <input type="checkbox"/> No <input type="checkbox"/> Yes
Other (list here):			

Musculoskeletal System	Response	Year Diagnosed	Comments
Osteoarthritis / Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Rheumatoid Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Fractures	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Fibromyalgia	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes		Have you had a recent bone mineral density scan? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, date: yyyy/mm _____
Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes		Have you had a recent bone mineral density scan? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, date: yyyy/mm _____
Whiplash	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Concussion	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Chronic Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Other (list here):			

COVID-19

Have you ever been diagnosed with COVID-19? No Yes

If yes, please indicate date of diagnosis (yyyy/mm/dd): _____

Do you have any ongoing COVID-19 symptoms (i.e., shortness of breath, chronic fatigue, exercise intolerance, chest tightness)? Please list: _____

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Have you received the COVID-19 vaccine(s)? No Yes
 Partially vaccinated (1 dose) Fully vaccinated (2 doses)

Diabetes

Have you been diagnosed with diabetes? No Yes

If yes, indicate what type: Type I Type II Pre-diabetes Gestational

Date of diagnosis (yyyy/mm/dd): _____

Average fasting blood sugar: _____

Average blood sugar range: _____

Diabetes medications: _____

Diabetes followed by:

Diabetes Education Center (name center): _____

Diabetes Nurse / Dietitian / Educator in your Primary Care Clinic

Primary Care Physician, Nurse Practitioner or Physician Assistant

Do you have any complications from your diabetes? No Yes, if yes check all that apply:

Vision problems Kidney problems Numbness in hands and/or feet (circle one or both)

Poor circulation Other: _____

Surgical History

List all of the surgeries that you have had (including laparoscopic) and any complications experienced with each surgery.

Surgery	Date (yyyy/mm)	Laparoscopically	Complications
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	

Mental Health History

Have you ever been diagnosed with a mental health disorder? (example: depression, anxiety, bipolar disorder, obsessive compulsive disorder, post-traumatic stress disorder, schizophrenia, attention deficit disorder / attention deficit hyperactivity disorder, personality disorder).

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Please check any or all that apply:

Anxiety Disorder

No Yes

Counselling/ Psychotherapy: Current Past

Medication _____

Depression

No Yes

Counselling/ Psychotherapy: Current Past

Medication _____

Post Traumatic Stress Disorder

No Yes

Counselling/ Psychotherapy: Current Past

Medication _____

Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder

No Yes

Counselling/ Psychotherapy: Current Past

Medication _____

Other diagnosed mental health disorders (include current treatment):

How would you self-report your **average** weekly stress level on a scale of 0 (no stress) to 10 (most stress)?
Number (0 to 10): _____

Please check any of the following sources of stress that you are currently experiencing:

Financial Family/ relationships Legal Health status Work Exercise

Other: _____

How would you rate your overall sleep?

No significant sleep concerns

Occasional sleep difficulties

Regular sleep difficulties (ex. falling asleep, staying asleep or early waking)

Do you have any strategies or use aids that help you sleep? _____

Substance Use History

Smoking/ Nicotine Use

Never smoked

Have you had exposure to significant second hand smoke?

Yes No

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Current smoker Smokes _____ package(s) per day.

Number of years smoked: _____

Age you started smoking: _____

Currently trying to quit smoking; method: _____

Occasionally smokes; indicate how often: _____

I currently use: Cigarettes Cigars Pipe Vaping Other: _____

Reformed smoker; Quit date: _____; smoked _____ package(s) per day since age _____

Cannabis Use

No cannabis use Yes; if yes, please check all that apply: Smoking Vaping Edibles

How often do you use cannabis? Daily Weekly Monthly Infrequent

Alcohol Use

No, I don't drink Yes, I drink. Number of alcoholic drinks per week: _____

I have previous issues with alcohol use, but I no longer drink

Do you **presently** use street drugs or prescription drugs outside of medical reasons?

No Yes; if yes, check all that apply:

Cocaine Opioids Inhalants Sedatives Hallucinogens Methamphetamines

Stimulants Other: _____

List any other health issues that you want the team to be aware of:

Medication History

Write down all of your medications, including over the counter medications and supplements (herbal, vitamin, dietary etc...), and the reasons you are taking them. If there is not enough space, please attach a neat and readable copy with the name of the medication/supplement, dose, how often you take them and the reason why you take the medication.

Pharmacy: _____

Address: _____ **Phone number:** _____

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Prescription Medication	Dose	How Often	Reason

Over the Counter Medication	Dose	How Often	Reason

Vitamin/ Supplements (Herbal & Other)	Dose	How Often	Reason

Medication allergies: write down all the medications you have an allergic reaction to & describe the reaction.

Medication	Describe Reaction

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Other allergies: write down all other food & materials you have an allergic reaction to and describe the reaction.

Allergen	Describe Reaction

Mobility

Do you have any difficulty walking? No Yes (please explain): _____

Do you use a walking aid? No Yes (indicate type): _____

Do you have a history of falls? No Yes

If yes, have you fallen within the last 12-months? No Yes: number of times: _____

If yes, indicate the date of your most recent fall (yyyy/mm/dd): _____

Please describe details of any recent falls and balance problems: _____

Physical Activity & Leisure

What of the following best describes your current lifestyle?

- Inactive (seated or reclined most of the day, household chores)
- Somewhat active (walking or other planned exercise/physical activity 15 to 30 minutes daily)
- Active (walking or other planned exercise/physical activity for more than 30 minutes daily)
- Other: _____

Describe if and when you feel short of breath. Please rate it on a 0 to 10 scale with 0 being not short of breath at all and 10 being the most short of breath.

At rest? No Yes, rating: _____/10

Climbing one flight of stairs? No Yes, rating: _____/10

Climbing 3 flights of stairs? No Yes, rating: _____/10

List any other activities that make you feel short of breath: _____

Do you walk regularly? No Yes Walking Pace: Slow Moderate Brisk

How many days per week do you walk on average? _____ Duration of walks: _____ minutes

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I measure my steps with: Not applicable, I do not measure my steps
 Pedometer Activity tracker (indicate type): _____
 Average Daily Step Counts: _____ steps/day

What other physical activities do you enjoy doing to stay active? (Check all that apply)

- Gardening/Yard work Household chores Hiking Aquafit Swimming Yoga
 Canoeing/Kayaking Outdoor cycling Skiing Skating Hockey Dancing
 Going to the gym Exercise videos Being active with my children/grandchildren

Other: _____

What are your barriers to being physically active? (Check all that apply)

- Lack of time Family obligations Lack of motivation / Energy Lack of resources/ Equipment
 Fear or anxiety Pain / Discomfort Not sure how to get started Cost
 Other: _____

List any other leisure activities that you enjoy: _____

Do you have any physical limitations to your daily activities? No Yes (please describe): _____

Do you experience calf pain or cramping every time you walk on level ground? No Yes

Exercise

Have you ever exercised before? No Yes

Have you ever been a member at a gym? No Yes, If yes, which one? _____

Are you currently participating in any exercise? No Yes

If yes, check the boxes that apply below and provide details as able:

	Number of times per week	Duration of each session	Details (e.g. stationary bike, treadmill, free weights, etc.)
Aerobic Exercise			
Strength Training			
Stretching			

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When did you last exercise? _____

What types of exercise have you done in the past? (please list): _____

List any exercise equipment you have at home (example: stationary/outdoor bike, treadmill, skis, skates, free weights, exercise bands): _____

Do you have any physical limitations that prevent you from exercising? Please explain: _____

Do you have any specific questions or concerns that you would like us to address at your initial assessments?

Who completed this questionnaire? Myself Someone else, please specify: _____

Thank you for taking the time to complete this questionnaire.

We look forward to meeting you!

Clear Form

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