NAME: Date of Birth:

CORONARY HEART DISEASE REVIEW

Height Weight

This questionnaire is for a routine review of your Coronary Heart Disease symptoms, please complete this questionnaire and return it at your earliest convenience. Your answers will always be seen by one of the practice team who will be in touch, if necessary.

# CHD Review

|  |  |
| --- | --- |
| **Symptoms:** In the last month have you suffered from angina (chest pain) during exercise? | |
| Yes | No |

**Triggers:** Please indicate if you have any triggers for angina, e.g. how far can you walk?

**Medication:** Do you have an in-date GTN (glyceryl trinitrate\*) medicine for angina episodes?

|  |  |  |
| --- | --- | --- |
| Yes | No | Not sure |

\*This is normally a spray or tablet taken under the tongue to help relieve angina symptoms

**In the last month:** How often have you used your GTN medicine?

|  |  |  |
| --- | --- | --- |
| 3 or more times per day | 2-3 times a day | Once or twice a day |
| Once a week or less | Not at all |  |

# Breathlessness/Fatigue

|  |  |
| --- | --- |
| Do you suffer from sudden waking at night due to shortness of breath? | |
| Yes | No |

|  |  |
| --- | --- |
| I can perform all physical activity without getting short of breath | |
| Yes | No |
| I get breathless or tired performing more strenuous activities, e.g. walking on a steep incline or walking up several flights of stairs | |

|  |  |
| --- | --- |
| Yes | No |

|  |  |
| --- | --- |
| I get breathless or tired performing day to day activities, e.g. walking on the flat | |
| Yes | No |

|  |  |
| --- | --- |
| I get breathless or tired at rest and am mostly housebound. I am unable to carry out any physical activity without  getting symptoms | |
| Yes | No |

**Oedema:** Do you have any Oedema (excess water causing swelling in the tissues)?

|  |  |  |
| --- | --- | --- |
| None | Mild (resolves at rest) | Moderate (e.g. mid calf/below knee) |
| Above knee | Thigh/Abdomen |  |

**Blood Pressure Readings**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **AM** |  |  |  |  |  |  |  |
| **PM** |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **AM** |  |  |  |  |  |  |  |
| **PM** |  |  |  |  |  |  |  |

## Taking your reading

Place the cuff on your arm, with the bottom of the cuff approximately 2cm above the bend in your elbow. Always measure your blood pressure in the same arm. Make sure that you are sitting down and have both feet flat on the floor. Do not cross your legs. Support your arm on a firm surface with your palm facing up. Do not talk and try to relax.

Take two readings at least 1 minute apart. If the first two readings are very different, take 2 or 3 further readings. Keep a record of your readings then enter them here. Ideally take two readings twice a day for 4-7 days, to give a total of up to 28.

**Pulse Rate:** You can check your heart rate by taking your pulse and counting how many times your heart beats in a minute. Your pulse will also be shown on most blood pressure machines. **Pulse**

# Medication

|  |  |
| --- | --- |
| Do you understand the purpose of your medication? | |
| Yes | No |

Do you suffer from any side effects?

Yes

No

If yes, please include details

|  |  |
| --- | --- |
| Do you take your medication as prescribed? | |
| Yes | No |

|  |  |
| --- | --- |
| Any difficulty taking them, or do you need assistance from someone else | |
| Yes | No |
| Do you have any issues ordering your medication? | |
| Yes | No |

|  |  |
| --- | --- |
| Do you take any over the counter medications, complimentary, herbal, or Chinese medication? | |
| Yes | No |

|  |  |
| --- | --- |
| Do you take any medication prescribed by a hospital or another clinic? | |
| Yes | No |
| Are there any changes to the dosages of your medication, which we are unaware of? | |
| Yes | No |

|  |  |
| --- | --- |
| Are you receiving medication you no longer require? | |
| Yes | No |

|  |  |
| --- | --- |
| Are you interested in cutting back medication, if agreed and safe to do so? | |
| Yes | No |
| Are there any changes to the dosages of your medication, which we are unaware of? | |
| Yes | No |