Ringwood Medical Practice
1st Floor, Ringwood Medical Centre, Ringwood, Hampshire, BH24 1JY
01425 478901 hiowicb-hsi.enquiries-rmc@nhs.net

FULL NAME: _____

DATE OF BIRTH: _____

CORONARY HEART DISEASE REVIEW

Height	
Weight	
Units of Alcohol?	
Do you Smoke?	

Giving up smoking is the best thing you can do for your health and you're up to four times more likely to give up with help from your local stop smoking service. An online secure referral form can be found at www.smokefreehampshire.co.uk. Alternatively, you can email smokefree.hampshire@nhs.net , telephone 01264 563039 / 0800 772 3649 or text QUIT to 66777.

CHD Review

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.

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 ☐	

Heart Health

Symptoms: The most common symptoms of heart failure are breathlessness, tiredness, and palpitations

I can perform all physical activity without symptoms ☐	I get symptoms when performing more strenuous activity ☐	I get symptoms when performing day to day activities ☐
I am unable to carry out any physical activity without symptoms ☐		

Exercise: How would you describe your tolerance when exercising

Good ☐	Fair ☐	Moderate ☐
Poor ☐		

Fatigue: How often do you experience feeling unusually tired and weak

Not at all ☐	After moderate physical activity ☐	After mild physical activity ☐
After minimal physical activity ☐	At rest ☐	

Swelling/Oedema: This is excess water causing swelling in the tissues. It most commonly affects the feet and ankles, but can occur higher up the leg or abdomen

None ☐	Mild (resolves after rest) ☐	Moderate (mid-calf / bellow knee) ☐
Above knee ☐	Thigh / Abdomen ☐	

Waking at Night: Do you suffer from sudden waking at night due to shortness of breath?

Yes ☐	No ☐

Fluid: How much fluid do you drink each day?

Less than 1 litre ☐	1 – 1.5 litres ☐	1.5 – 2 litres ☐
More than 2 litres ☐		

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, complementary, 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 ☐

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