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

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

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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.

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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 ☐

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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 ☐