

MRN: _____ Encounter Date: **mm / dd / yyyy** Practice ID: _____ Location ID: _____

Physician Name (Last, First MI): _____ Physician NPI: _____

A. PATIENT DEMOGRAPHICS

Patient Name (Last, First MI): _____ SSN: _____ Patient new to the Practice

Date of Birth: **mm / dd / yyyy** Sex: Male Female Patient Zip: _____

Race: (Check all that apply)
 White Black/African American Asian Hispanic or Latino Ethnicity
 American Indian/Alaska Native Native Hawaiian/Pacific Islander

Insurance Payers: (Check all that apply) Payer ID: _____
 Private Health Insurance Medicare (fee for service) Medicare (managed care) Medicaid Military Health Care
 State Specific Plan (non-Medicaid) Indian Health Service Non-US Insurance None

B. DIAGNOSES/CONDITIONS/CO-MORBIDITIES Note: Indicate if the patient has a history of any of the following.

Coronary Artery Disease Atrial Fibrillation/Flutter Dyslipidemia Diabetes Mellitus
 Hypertension Systemic Embolism Peripheral Arterial Disease Prior Stroke/TIA
 Unstable Angina Heart Failure → (If Yes), New diagnosis (within 12 months)
 Stable Angina → (If Yes), New diagnosis (within 12 months)

C. CARDIAC EVENTS Note: Indicate if the patient has a history of any of the following.

Myocardial Infarction (any history of) → (If Yes), Myocardial Infarction (within 12 months)
 Coronary Artery Bypass Graft (within 12 months) PCI - Bare Metal Stent Implant (within 12 months)
 Cardiac Valve Surgery (within 12 months) PCI - Drug Eluting Stent Implant (within 12 months)
 Heart Transplantation (within 12 months) PCI - Other (non-stent) Intervention (within 12 months)

D. ENCOUNTER INFORMATION Note: Complete only if assessed during today's encounter. If not assessed, leave blank.

Height: _____ O in cm Blood Pressure: _____ / _____ mmHg Heart Rate: _____ bpm

Weight: _____ O lbs kg Patient unable to be weighed

Tobacco Use: Never Current Quit within past 12 months Quit more than 12 months ago Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco
 → If Current or Quit within 12 months, Cigarettes Cigars Pipe Smokeless
 → If Current or Quit within 12 months, Smoking Cessation Counseling: No Yes

Advance Care Plan OR Discussion of Advance Care Plan Documented: No Yes

ANGINA SYMPTOMS AND ACTIVITY ASSESSMENT(S)

CAD CCS Class: No angina I II III IV Other Tool/Method Used to Assess Angina Symptoms and Activity Completed
 Seattle Angina Questionnaire Completed

HEART FAILURE ACTIVITY ASSESSMENT(S)

HF NYHA Class: I II III IV Chronic Heart Failure Questionnaire from Guyatt Completed
 Kansas City Cardiomyopathy Questionnaire Completed Other Tool/Method Used to Assess Heart Failure Activity Completed
 Minnesota Living with HF Questionnaire Completed

HEART FAILURE SYMPTOMS ASSESSMENT(S)

HF Dyspnea Present: No Yes Orthopnea Present: No Yes

HEART FAILURE PHYSICAL ASSESSMENT(S)

HF Rales Present: No Yes Peripheral Edema Present: No Yes S₃ Gallop Present: No Yes
 Ascites Present: No Yes Hepatomegaly Present: No Yes S₄ Gallop Present: No Yes
 Jugular Venous Distention Present: No Yes

PLAN OF CARE

HTN Hypertension plan of care documented: No Yes Note: Required for patients that have been diagnosed with Hypertension.

