

<b>Name:</b> <b>Date:</b> <b>Physician:</b>	<b>ACC HF stage</b> <input type="checkbox"/> A high risk <input type="checkbox"/> B Asymp <input type="checkbox"/> C Symp <input type="checkbox"/> D EndStage <b>NYHA Class</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV Symptoms: none w ordinary activity w less than ordinary at rest/minimal <b>EF</b> _____% Date _____ <input type="checkbox"/> Systolic dysfunction <input type="checkbox"/> Diastolic dysfunction <input type="checkbox"/> Valvular Likely Etiology: <input type="checkbox"/> ischemic <input type="checkbox"/> HTN <input type="checkbox"/> other _____
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<b>Chief Complaint:</b> Wt: _____ change? _____ time interval _____ BP sitting _____ standing _____ Smoking status _____ packs per day _____ Sleeping: (Check one) <input type="checkbox"/> Well <input type="checkbox"/> Fair <input type="checkbox"/> Poor Snoring: <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumovax given? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Flu shot? <input type="checkbox"/> Not due or already given <input type="checkbox"/> Due Given _____	<b>Symptoms and Physical Findings</b> <input type="checkbox"/> Dyspnea _____ <input type="checkbox"/> Paroxysmal nocturnal dyspnea <input type="checkbox"/> Orthopnea <input type="checkbox"/> Cough <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain _____ <input type="checkbox"/> Abdominal complaints _____ <input type="checkbox"/> Cardiac rhythm _____ JVP _____ Lungs <input type="checkbox"/> Rales _____ Other <input type="checkbox"/> Ascites <input type="checkbox"/> Distal edema _____
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**Comorbidities:**  Diabetes  Hyperlipidemia  Hypertension  Atrial fibrillation  Renal Insuff

Drugs: ACC Class I for LVSD	<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>If not, why?</u>
ACE Inhibitor	_____	_____	_____	_____
HF Beta Blocker	_____	_____	_____	_____
(bisoprolol, carvedilol)	_____	_____	_____	_____
Warfarin for A fib	_____	_____	_____	_____
Other medications	<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	
Diuretic(s)	_____	_____	_____	_____
Sliding Scale diuretic	_____	_____	_____	_____
Spironolactone	_____	_____	_____	_____
ARB	_____	_____	_____	_____
Aspirin	_____	_____	_____	_____
Statin	_____	_____	_____	_____
Other	_____	_____	_____	_____
Other	_____	_____	_____	_____
Other	_____	_____	_____	_____
Other	_____	_____	_____	_____

**Medications Changed?** \_\_\_\_\_

<b>Notes</b>    	<b>Plan (Check all that apply)</b> <input type="checkbox"/> Echo _____ <input type="checkbox"/> B-type NP _____ <input type="checkbox"/> Lytes/Creat _____ <input type="checkbox"/> CBC _____ INR _____ _____ _____ <input type="checkbox"/> Noninvasive myocardial imaging <b>Next appointment</b> _____ <input type="checkbox"/> weeks/ <input type="checkbox"/> mos.
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**Heart Failure Education**  
 General  Daily weights  Smoking cessation  Medications  Diet \_\_\_\_\_  Activity

**Activity recommendation** \_\_\_\_\_

**Self Management Goal:** \_\_\_\_\_

(Patient to set goal at the end of each visit)

**Other instructions** \_\_\_\_\_

**Physician signature** \_\_\_\_\_ **Date** \_\_\_\_\_