THE HEART INSTITUTE®
breakthroughs are in our blood

North Shore LIJ Staten Island University Hospital

Instructions: Please print and fill out this form before your first office visit.

Name: _____ **Date:** _____

Procedure: _____Date of Procedure_____Date of Discharge: _____

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1. Are you showering daily?	Yes ___ No___
2. Do you have a problem sleeping at night?	Yes ___ No___
3. Is your appetite improving?	Yes ___ No___
4. Do you become short of breath easily?	Yes ___ No___
5. Do you use your breathing machine as instructed?	Yes ___ No___
6. Is the level going lower on the breathing machine?	Yes ___ No___
7. Are you short of breath at rest?	Yes ___ No___
8. Do you sleep on three or more pillows?	Yes ___ No___
9. Do you have chest wall numbness or tingling sensation?	Yes ___ No___
10. Do you have pain or numbness in your fingertips?	Yes ___ No___
11. Do you feel or hear clicking in your chest?	Yes ___ No___
12. Have you had a chronic cough or cold since discharge?	Yes ___ No___
13. Are your legs swollen most of the time?	Yes ___ No___
14. Do you wear your support stockings during the day?	Yes ___ No___
15. If you are a diabetic has your sugar been maintained less than 200?	Yes ___ No___
16. Do you take your temperature daily?	Yes ___ No___
17. Have you had a recent fever?	Yes ___ No___
18. Did you develop a wound infection after surgery?	Yes ___ No___
19. Have you seen your cardiologist since discharge from hospital?	Yes ___ No___
20. Have you seen your primary physician since discharge from hospital?	Yes ___ No___
21. Have you required any medical treatment since discharge?	Yes ___ No___
22. Have any of your medications changed since leaving the hospital?	Yes ___ No___
23. Do you still have moderate to severe pain?	Yes ___ No___

On a pain scale of 0 – 10 (0 being no pain) please circle the appropriate # for you.

0 1 2 3 4 5 6 7 8 9 10

Do you have any complaints or concerns?

Reviewed by: _____ Date: _____