

Heart Failure Quiz

1. Heart failure means:

- A. My heart can't pump blood as well as it should.
- B. Extra fluid can pool in my lungs and body.
- C. My body isn't getting enough oxygen in my blood.
- D. All of the above.

2. How long do you need to take medicines to control your heart failure symptoms:

- A. Until the symptoms go away.
- B. For the rest of my life.
- C. Until I feel better.
- D. None of the above.

3. The most sodium (salt) you can have every day is:

- A. 1,000 to 1,500 mg
- B. 1,500 to 2,000 mg
- C. 2,000 to 2,500 mg
- D. None of the above.

4. You will be able to eat deli meats, pickles, olives and canned soups:

- A. True
- B. False

5. You need to weigh yourself every day:

- A. True
- B. False

6. If you gain 3 pounds in 1 day or 5 pounds in 1 week:

- A. Call your health care provider right away.
- B. Start dieting to lose weight.
- C. Take extra medicine.
- D. Don't worry about it.

7. It is OK to have one beer once a week:

- A. True
- B. False

8. The most liquids you can drink in one day is:

- A. 1 liter
- B. 2 liters
- C. 3 liters
- D. 4 liters

9. Exercising every day is important to:

- A. Maintain a healthy weight.
- B. Help your muscles get stronger.
- C. Help your heart pump oxygen-rich blood through your body.
- D. All of the above.

10. Understanding what to do if your symptoms change from day to day is important to:

- A. Avoid a hospital stay.
- B. Prevent the symptoms from becoming worse.
- C. Help you feel as good as you can.
- D. All of the above.

11. The “Heart Failure Action Plan” (on page 5):

- A. Is a helpful list I will look at when my symptoms change.
- B. Is just a suggestion I only need to follow if I want to.
- C. Is important for me to understand what to do when my symptoms become worse.
- D. A and C.

12. You and your health care team will work together to find the best treatments for you.

- A. True
- B. False

Answers:

1. D 2. B 3. B 4. B 5. A 6. A 7. B 8. B 9. D 10. D 11. D 12. D 13. A

Personal Health Profile

Personal Health History

Please list any illnesses or health problems you have had (such as rheumatic fever, pneumonia) or any chronic (long-lasting) illness you have (such as diabetes, high blood pressure, cancer).

Date	Illness or Problem
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Hospital Stays

Please list any illnesses or surgeries that required you to stay in a hospital.

Date	Reason	Hospital
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Health Records

Exam	Date Done	Date Due	Comments
Complete physical exam			
Lipids (cholesterol, LDL, HDL, triglycerides)			
Rectal exam			
Hemoccult (check for blood in the stool)			
Colon screening (flex sig or colonoscopy)			
Prostate exam			
Breast exam			
Pap smear			
Mammogram			
Eye exam			
Dental visit			

Shot	Date Done	Date Due	Comments
Flu (influenza)			
Pneumonia			
Tetanus (due every 10 years)			
Other			

Schedule of Appointments

Date	Time	Location	Doctor/Nurse

Office Visits and Lab Tests

Date	Reason for Visit	Follow-up Recommended

Blood Pressure and Pulse Record

Date	Pulse	Left: Stand or Sit	Right: Stand or Sit

Home Exercise Program

When you complete your timed exercise, please fill out the boxes below.

Date	Time	Morning	Afternoon	Evening	Symptoms/Feelings
	4 min.				
	5 min.				
	6 min.				
	7 min.				
	8 min.				
	9 min.				
	10 min.			May decrease exercise to twice a day.	
	11 min.				
	12 min.				
	13 min.				
	14 min.				
	15 min.				
	16 min.				
	17 min.				
	18 min.				
	19 min.				
	20 min.		May decrease exercise to once a day.		
	21 min.				
	22 min.				
	23 min.				
	24 min.				
	25 min.				
	26 min.				
	27 min.				
	28 min.				
	29 min.				
	30 min.				

Home Exercise Program

When you complete your timed exercise, please fill out the boxes below.

Date	Time	Morning	Afternoon	Evening	Symptoms/Feelings
	4 min.				
	5 min.				
	6 min.				
	7 min.				
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	22 min.				
	23 min.				
	24 min.				
	25 min.				
	26 min.				
	27 min.				
	28 min.				
	29 min.				
	30 min.				

Current Medicine List

Pharmacy: _____ Phone: _____

Doctor: _____ Phone: _____

Medicine allergies: _____

Medicine and reason for taking	Dose	Break-fast	Lunch	Midday	Supper	Bedtime	Comments

Current Medicine List

Pharmacy: _____ Phone: _____

Doctor: _____ Phone: _____

Medicine allergies: _____

Medicine and reason for taking	Dose	Break-fast	Lunch	Midday	Supper	Bedtime	Comments

Questions or Notes



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