



# JHS Heart Failure

OMB# 0925-0491  
EXPIRATION DATE XX/XXXX

FORM CODE: **HFS**  
VERSION A: 12/12/2007

ID NUMBER: \_\_\_\_\_

CONTACT YEAR NUMBER: \_\_\_\_\_ SEQUENCE NUMBER \_\_\_\_\_

PATIENT NAME: Ms./Mr. \_\_\_\_\_ PATIENT DATE OF BIRTH \_\_\_\_\_  
Last Name First Name MM/DD/YYYY

1. Has this patient ever had heart failure or cardiomyopathy of any type?

Yes  Unsure  No

**(If response is NO, skip to**

2. If this patient has or ever had heart failure or cardiomyopathy:

a. Is this patient's condition characterized as predominantly:

Systolic dysfunction  Diastolic dysfunction  Mixed  Not determined

b. Estimate LVEF (worst): \_\_\_\_\_%

(b.1) If LVEF is not specifically available, estimate LV function:

Normal  Decreased mildly  Decreased moderately  Decreased severely

c. Estimate date of onset or diagnosis: \_\_\_\_/\_\_\_\_ (Month/year)

3. Has this patient ever had **(check all that apply)**:

Atrial fibrillation on an ECG?  Pulmonary rales on a physical examination  
 Angina pectoris?  Rhonchi on a physical examination?  
 Previous MI?  Other coronary heart disease?  
 None of the above

4. Was she/he prescribed treatment specifically for heart failure during the past year?

Yes  No  Not known

5. Was this patient prescribed any of the following during the past year? (check all that apply)

ACE inhibitors  Anticoagulants  Diuretics  
 Alpha blockers  Aspirin / Antiplatelets  Hydralazine  
 Aldosterone blocker agents  Beta blockers  Lipid-lowering agents  
 Amiodarone / Antiarrhythmics  Calcium channel blockers  Nitrates  
 Angiotensin II receptor blocker  Digitalis  Other antihypertensives

6. Has the patient undergone any procedures related to HF? (Check all that apply)

ICD implantation  Re-synchronization therapy  Other

**Form Completed By:**

**Date:**

\_\_\_\_\_  
(Signature or stamp)

\_\_\_\_\_  
(MM/DD/YY)