OMB# 0925-0491
EXPIRATION DATE XX/XXXX

JHS Heart Failure

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?
   ☐ Angina pectoris?
   ☐ Previous MI?
   ☐ Pulmonary rales on a physical examination
   ☐ Rhonchi on a physical examination?
   ☐ 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
   ☐ Alpha blockers
   ☐ Aldosterone blocker agents
   ☐ Amiodarone / Antiarrhythmics
   ☐ Angiotensin II receptor blocker
   ☐ Anticoagulants
   ☐ Aspirin / Antiplatelets
   ☐ Beta blockers
   ☐ Calcium channel blockers
   ☐ Digitalis
   ☐ Diuretics
   ☐ Hydralazine
   ☐ Lipid-lowering
   ☐ Nitrates
   ☐ 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)