

### Heart Failure Clinic Progress Note

Date: \_\_\_\_\_

Addressograph

Subjective: Patient complaints/concerns: \_\_\_\_\_

Do you experience?		Yes	No	Comments:
<b>Dyspnea</b>	Difficulty breathing?			At rest <input type="checkbox"/> Minimal activity <input type="checkbox"/> Moderate activity <input type="checkbox"/> None <input type="checkbox"/>
<b>Orthopnea</b>	Difficulty breathing lying flat?			How many pillows do you sleep on at night?
<b>PND</b>	Awakening at night?			Due to shortness of breath? <input type="checkbox"/> To urinate? <input type="checkbox"/> Number of times/night?
<b>Cough</b>	Coughing?			Productive? Yes <input type="checkbox"/> No <input type="checkbox"/> Keep you awake at night? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Fatigue</b>	Increased fatigue?			Do you have enough energy to complete ADL's? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Syncope</b>	Lightheadedness?			Occurs getting up? Yes: <input type="checkbox"/> No: <input type="checkbox"/> Lost consciousness? Yes <input type="checkbox"/> No <input type="checkbox"/> Is it relieved by getting up slowly? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Chest Discomfort</b>	Chest discomfort?			Describe Tightness <input type="checkbox"/> Pressure <input type="checkbox"/> Other: Duration: _____ Pain Scale: _____ (0-10)
<b>Pain</b>	Pain other than chest pain?			Location: _____ Nature: _____ Duration: _____ Pain Scale: _____ (0-10)
<b>Edema</b>	Swelling?			Where? Feet <input type="checkbox"/> Ankles <input type="checkbox"/> Hands <input type="checkbox"/> Fingers <input type="checkbox"/> Abdomen <input type="checkbox"/>
<b>Palpitations</b>	Irregular heart beat?			
<b>Abdominal Discomfort</b>	Abdominal pain/tenderness?			
	Bloating?			
	Nausea?			Appetite: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
<b>Self Diuretic Admin.</b>	Taken extra diuretics?			How often? _____ Did you take extra potassium? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Exercise</b>	Inability to exercise?			Type of exercise/activity: _____
<b>Reported NON Compliance</b>	Medications?			Reason?
	Sodium restriction?			Reason?
	Fluid restriction?			Reason?
	Daily weight monitoring?			Did you bring your weight calendar? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Physician Visits</b>	Other M.D./ER visits or hospitalizations?			If yes, describe: _____
<b>Medications</b>	Any medication changes?			If yes, describe: _____
	Need medication refills?			If yes, what medications? _____
<b>Social</b>	Did you come alone?			Accompanied by: _____
<b>Insurance</b>	Changed your insurance?			If yes, business office notified? Yes <input type="checkbox"/> No <input type="checkbox"/>

**Objective:**

Wt:	Prior Wt./Date:	B/P↑	Pulse↑	B/P→	Pulse→	Temp:	Resp. Rate:	O2 Sat:	6MWT:	
CI:	SV:	SVR:	TFC:	ACI:	Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/>		Cardiac Rhythm:	Heart Tones:		
JVD: None(3) <input type="checkbox"/> Base(8) <input type="checkbox"/> Mid(14) <input type="checkbox"/> Ear (20) <input type="checkbox"/>		HJR: Pos. <input type="checkbox"/> Neg. <input type="checkbox"/>		Extremities: Cool <input type="checkbox"/> Warm <input type="checkbox"/> Nail beds: Pink <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/>			Edema: Location/Amount:			
Breath Sounds:		Abdomen:	MLWHF: Total:	Physical:	Emotional:	GDS:	NYHA: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/>			

**Laboratory:**

Sodium:	Potassium:	Chloride:	CO2:	BUN:	Creatinine:	Magnesium:	Glucose:
BNP:	WBC:	HGB:	HCT:	PLT:	INR:	TSH:	Digoxin Level:

