MISH
Minimally Invasive Surgery Hospital

Exercise Tolerance Screen

PATIENT NAME: ____ DOB: ______________ Date: ______________

Exercise tolerance testing Questions

1. Do you have a history of: heart disease, coronary heart disease or hardening of the arteries? YES NO
2. Have you ever had a heart catheterization or coronary angiogram? YES NO
3. Have you ever had a coronary balloon angioplasty (PTCA)? YES NO
4. Have you ever had a heart bypass operation (CABG)? YES NO
5. Have you ever had heart valve surgery? YES NO
6. Have you ever had or been told you had a heart attack (MI)? YES NO
7. Do you have any history of heart failure? YES NO
8. Are you presently having or have had in last 4weeks any of the following?
   a. Chest: pain, pressure, discomfort or burning YES NO
   b. Shortness of breath YES NO
   c. Awakening short of breath YES NO
   d. Difficulty breathing when lying flat YES NO
   e. Dizziness YES NO
   f. Fainting YES NO
   g. Irregular or skipped heart beats YES NO
   h. Swelling of the feet and/or ankles YES NO
   i. Fatigue or unusual tiredness YES NO
   j. Leg pain when walking (claudication) YES NO

Coronary artery disease risk factor questions

9. Do you have or have been told you have?
   a. High blood pressure YES NO
   b. Sugar diabetes YES NO
   c. High cholesterol YES NO
   d. High triglycerides YES NO
10. Dou you currently smoke? YES NO
11. Have you stopped smoking? YES NO
12. Do you smoke cigars or a pipe? YES NO
13. Do you chew tobacco? YES NO
14. Has a father, mother, brother, sister or grandparents had heart disease before age 60? YES NO
15. Do you adhere to a low-fat diet? YES NO
16. Do you exercise regularly? YES NO

Chest pain/discomfort questions

The following questions are focused on your chest pain symptoms in the last 6 months. *IMPORTANT: if you had any procedures performed on your heart in the last 6 months, describe the chest pain/symptoms since the procedure.*

17. Are you currently having or had chest pain/discomfort in last 6 months? YES NO
18. Does the pain occur in the center of your chest? YES NO
19. Does the pain occur elsewhere or radiate/move to any other areas? YES NO
20. Which of the following locations does your pain move to?
   a. Left side of chest YES NO
   b. Left or Right arm YES NO
   c. Neck or jaw YES NO

d. Back YES NO
e. Shoulders YES NO
f. Other YES NO

21. Does your pain or discomfort come on typically with physical exertion or emotional stress? YES NO
22. Is your pain or discomfort relieved typically with rest? YES NO
23. What other methods help relieve the pain discomfort?
24. Do you use nitroglycerin to relieve the chest pain or discomfort? YES NO
25. Approximately how many times per week do you get the per or discomfort (circle one)?
    0 1-5 5-10 More than 10
26. Compared to previous month, during this past month has your pain/discomfort been:
    a. Occurring more often? YES NO
    b. More severe or intense? YES NO
    c. Lasted longer than usual? YES NO
27. When did you first experience the pain and discomfort?
28. Do you have any of the following symptoms associated with the chest pain/discomfort?
    a. Shortness of breath YES NO
    b. Sweating YES NO
29. When you experience the pain/discomfort, how long does it typically last?
    30 sec 1 to 5 min 15 to 30 min more than 30 min

Patient medical history questions

30. Please list your current medications:

Drug Name	Drug dose	Drug frequency	Drug last taken

31. List allergies: ____
32. Circle any other significant medical problems:

Diabetes
Hypertension
Asthma
Sleep apnea
Pacemaker or ICD
Heartburn/Reflux
Peptic ulcer disease

Reviewing cardiologist signature: ____ *Date:* ______________