CARDIAC QUESTIONNAIRE

Claimant Name: **SSN:** **Date:**

1. Do you have any chest discomfort? ☐ **Yes** ☐ **No**

a) How often does it occur?

b) What brings on your chest discomfort?

c) What does it feel like?

d) How long do episodes last?

e) What relieves it?

f) Does it radiate? If so, where?

g) Does it occur at rest?

h) Does it awaken you from sleep?

2. Do you have shortness of breath? ☐ **Yes** ☐ **No**

a) When does it occur?

b) What brings it on?

c) What relieves it?

d) How far can you walk without stopping to rest?

e) How many flights of stairs you can climb without stopping to rest?

3. Do you have additional symptoms (for example fatigue, weakness, lightheadedness)? ☐ Yes ☐ No
If yes, describe:

4. List current cardiac medication(s):

MEDICATION, DOSAGE, AND FREQUENCY	DATE STARTED	IF PRESCRIBED, NAME OF HEALTH CARE PROFESSIONAL	SIDE EFFECT(S)

5. Describe any activities you have stopped due to shortness of breath or chest discomfort.

6. If you have seen any health care professionals for your cardiac conditions since you filed your claim, complete the chart below.

NAME OF HEALTH CARE PROFESSIONAL	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY)

Name of person completing this form	Date	Phone	
Address	City	State	Zip Code