

HEART ATTACK—MYOCARDIAL INFARCTION

CLIENT NAME: _____
Submit the Client Information Questionnaire with this form

1. List date(s) of the heart attack(s):

2. Has the client had any of the following:

__ echocardiogram	_____	date
__ coronary catheterization	_____	date
__ coronary angioplasty	_____	date
__ bypass surgery	_____	date
__ heart failure	_____	date
__ arrhythmias	_____	date

3. Is client taking any medication now (Y/N)? (accurate name, dosage, and reason)

4. Has a follow-up stress (exercise) ECG been completed since the heart attack?
__ yes, give details _____
__ no

5. Please check if your client has had any of the following:

__ abnormal lipid levels	__ diabetes; age of onset: _____
__ overweight	__ elevated homocysteine
__ high blood pressure	__ peripheral vascular disease*
__ irregular heartbeats*	__ cerebrovascular or carotid disease

**these conditions require an additional questionnaire to be completed, please request.*

6. Does client have any other major health problems? (if yes, give details)

Producer Name: _____

Please fax form to 612-392-7644 or email to mvp@mvp-servicesolutions.com