EECP Patient Pre-Screening Checklist

Patient Name: ___________________________ Date: ____________

Condition/Reason for interest in EECP: ____

Please answer the following with as much information as you have:

1) History of Heart Catheterization or surgery? Y / N Date: _______________
2) History of Congestive Heart Failure? Y / N Classification: ________________
   Ejection Fraction% _______________ Date Measured: _________________
3) Cardiomyopathy? Y / N
4) Aortic Insufficiency? Y / N Mild Moderate Severe
5) Mitral Valve Prolapse? Y / N Mild Moderate Severe
6) Abdominal Aortic Aneurysm? Y / N _____ cm
7) Congenital Heart Defects? Y / N _____________________________
8) Lung Disease? Y / N Mild Moderate Severe
9) Peripheral Vascular Disease? Y / N Mild Moderate Severe
   Date of last vascular study: ______________
10) History of Deep Vein Thrompophlebitis? Y / N
11) Bleeding Disorder? Y / N
12) Anti-Coagulation Therapy? Y / N PT INR ________ Last Date: ___________
13) Severe Hypertension (> 180 Systolic OR > 110 Diastolic)? Y / N
    Medication: ____
14) Heart Rates < 35 OR > 125? Y / N
15) Current Arrhythmias? Y / N Frequency? ___________________________
16) Pacemaker? Y / N
17) Diabetes? Y / N
18) Any Limb Restrictions (Vasculitis, Infections, Burns, Wounds, etc.)? Y / N
    Specify: ____
19) Active Cancer? Y / N

20) **Medication** (Please list all of your prescription and non-prescription medication, including birth control, aspirin, and over the counter medications)

Medication	Dosage	Since	Reason

Are you currently experiencing any side effects from your medication? Yes No

Signature: ______________________________ Date: ___________________________