

# ENLARGED HEART



CLIENT NAME: \_\_\_\_\_

Submit the Client Information Questionnaire with this form

1. When was the condition first diagnosed? \_\_\_\_\_

2. Have any of the following symptoms occurred?

Chest discomfort	___	yes	___	no
Fainting spells or dizziness	___	yes	___	no
Shortness of breath	___	yes	___	no
Palpitations (irregular heart beat)	___	yes	___	no

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

Chest X-ray	___	yes-normal	___	no
	___	yes-abnormal		
Exercise treadmill or thallium	___	yes-normal	___	no
	___	yes-abnormal		
Resting or exercise echocardiogram	___	yes-normal	___	no
	___	yes-abnormal		
MUGA	___	yes-normal	___	no
	___	yes-abnormal		
Cardiac catheterization	___	yes-normal	___	no
	___	yes-abnormal		

4. Is there a history of any heart disease (problems with valves, coronary artery disease, cardiomyopathy, etc.)?

\_\_\_ Yes; please give details \_\_\_\_\_  
\_\_\_ No \_\_\_\_\_

5. Is client on any medications? (accurate name, dosage, and reason)

6. Does your client have any other health problems? (additional questionnaires may be required)