

# Heart and Cardiovascular Assessment

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

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## History

*Review of history related to heart and cardiovascular system:*

YES/NO	If YES, provide details:
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### General

<input type="checkbox"/> <input type="checkbox"/>	Smoking	_____
<input type="checkbox"/> <input type="checkbox"/>	Fatigue	_____
<input type="checkbox"/> <input type="checkbox"/>	Overweight/obesity	_____
<input type="checkbox"/> <input type="checkbox"/>	Level of stress	_____
<input type="checkbox"/> <input type="checkbox"/>	Exercise	_____
<input type="checkbox"/> <input type="checkbox"/>	Alcohol consumption	_____
<input type="checkbox"/> <input type="checkbox"/>	Diet	_____
<input type="checkbox"/> <input type="checkbox"/>	Diabetes mellitus	_____

### Cardiovascular

<input type="checkbox"/> <input type="checkbox"/>	Cardiac disease history	_____
<input type="checkbox"/> <input type="checkbox"/>	Chest pain or tightness	_____
<input type="checkbox"/> <input type="checkbox"/>	Irregular heartbeat	_____
<input type="checkbox"/> <input type="checkbox"/>	Unexplained dizziness	_____
<input type="checkbox"/> <input type="checkbox"/>	Blood pressure problems	_____
<input type="checkbox"/> <input type="checkbox"/>	Shortness of breath	_____
<input type="checkbox"/> <input type="checkbox"/>	Orthopnea	_____
<input type="checkbox"/> <input type="checkbox"/>	Cough	_____
<input type="checkbox"/> <input type="checkbox"/>	Edema or cold hands or feet	_____
<input type="checkbox"/> <input type="checkbox"/>	Color changes/hands	_____
<input type="checkbox"/> <input type="checkbox"/>	Color changes/lower legs or feet	_____
<input type="checkbox"/> <input type="checkbox"/>	Swelling/ankles or legs	_____
<input type="checkbox"/> <input type="checkbox"/>	Nocturia	_____

**Focused symptom analysis of current problem:**

**Reason for visit:** \_\_\_\_\_  
\_\_\_\_\_  
**Character:** \_\_\_\_\_  
**Onset:** \_\_\_\_\_  
**Duration:** \_\_\_\_\_  
**Location:** \_\_\_\_\_  
**Severity:** \_\_\_\_\_  
**Associated problems:** \_\_\_\_\_  
**Efforts to treat:** \_\_\_\_\_

***Current medications (note hormones):***

\_\_\_\_\_

***Social history (fitness/exercise, stress reduction, nutrition):***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Sleep/rest patterns:*** \_\_\_\_\_

\_\_\_\_\_

***Family history of heart or cardiovascular system (especially cardiac arrest), or diabetes mellitus:***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Physical Assessment

### Height and weight:

Height in inches: \_\_\_\_\_ Weight in pounds: \_\_\_\_\_ BMI: \_\_\_\_\_

		TIME OF ASSESSMENT			
Hour		AM PM	AM PM	AM PM	AM PM
<b>Pulse</b> R = Radial A = Apical  <b>Rhythm</b>					
Right	BP Systolic Diastolic				
Left	BP Systolic Diastolic				

### Cardiovascular System: Inspection and Palpation

**General characteristics** (skin color, temperature and tone, cyanosis, nail clubbing or spooning, venous stasis): \_\_\_\_\_  
 \_\_\_\_\_

**Anterior chest** (color, symmetry, contour, scars, venous pattern, apical impulse, pulsations/thrills/heaves): \_\_\_\_\_  
 \_\_\_\_\_

**Carotid and jugular vessels** (pulsations, distention): \_\_\_\_\_

**Abdominal vessels** (aorta, iliac, renal pulsations): \_\_\_\_\_

**Peripheral circulation** (arms, legs, hands and feet for temperature, color and pulses, ulcers and skin condition): \_\_\_\_\_  
 \_\_\_\_\_

***Auscultation (with diaphragm and bell):***

**All cardiac locations** (rate, rhythm, S1, S2, note any extra sounds, splits, murmurs):

**Aortic:** \_\_\_\_\_  
**Pulmonic:** \_\_\_\_\_  
**Tricuspid:** \_\_\_\_\_  
**Mitral:** \_\_\_\_\_

**Auscultate arteries for bruits.**

**Carotid:** \_\_\_\_\_  
**Abdominal aorta:** \_\_\_\_\_  
**Iliac arteries:** \_\_\_\_\_  
**Renal arteries:** \_\_\_\_\_

**Analysis:**

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