UNDERSTANDING YOUR SIGNS AND SYMPTOMS

This page provides information on common signs and symptoms of heart failure. Ask your doctor what you should do if your symptoms change, become persistent, or get worse.

The information provided here is not meant as a substitute for professional healthcare or medical advice. Remember to talk with your healthcare provider to learn more about your own diagnosis, treatment, or condition. Also, consult with your healthcare provider prior to any lifestyle modifications or changes in your daily routine.

Be sure to write down any questions you may have for your doctor or nurse and schedule an appointment if you are concerned about your symptoms.

Either fill in the blanks and/or record your measurements on the table on the reverse side. Start tracking your symptoms the day after your appointment.

DIFFICULTY BREATHING

When you feel shortness of breath when active or at rest, or if you are wheezing or having trouble breathing.

FATIGUE

When you feel tired or weak.

SWELLING

When you have swelling in your feet, ankles, legs, or abdomen.

HEART RATE

When your pulse or heart rate gets very slow or very fast, or it is not regular (measured as beats per minute [BPM]).

APPETITE CHANGE

When you notice a change in your appetite or problems with digestion.

DIZZINESS

When you feel dizzy or light-headed.

WEIGHT GAIN

When your weight goes up more than 3 pounds in a day or 5 pounds in a week.

BLOOD PRESSURE

When your blood pressure is higher or lower than your doctor says is normal for you.

COUGHING/WHEEZING

When you have a cough that does not go away. It may be dry and hacking or it may sound wet and productive.

CHEST PAIN

When you feel pain or pressure in your chest.

Hamilton Cardiology ASSOCIATES

WEEK ___	DAY ___	DAY ___	DAY ___	DAY ___	DAY ___	DAY ___	DAY ___
DATE (MONTH/DAY)	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____
DIFFICULTY BREATHING	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No
FATIGUE	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No
SWELLING If so, where?	O Yes O No _____	O Yes O No _____	O Yes O No _____	O Yes O No _____	O Yes O No _____	O Yes O No _____	O Yes O No _____
HEART RATE (BPM)							
APPETITE CHANGE	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No
DIZZINESS	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No
WEIGHT (LBS)							
BLOOD PRESSURE	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____
COUGHING/WHEEZING	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No
CHEST PAIN	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No

WEEK ___	DAY ___	DAY ___	DAY ___	DAY ___	DAY ___	DAY ___	DAY ___
DATE (MONTH/DAY)	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____
DIFFICULTY BREATHING	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
FATIGUE	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
SWELLING If so, where?	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____	Yes No _____
HEART RATE (BPM)							
APPETITE CHANGE	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
DIZZINESS	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
WEIGHT (LBS)							
BLOOD PRESSURE	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____
COUGHING/WHEEZING	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
CHEST PAIN	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Record any questions or comments you may have for your healthcare provider here

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