

# LIST OF SYMPTOMS ASSOCIATED WITH THE MANAGEMENT OF HEART FAILURE

SYMPTOMS	FREQUENCY OF SYMPTOMS				
	Never	Sometimes	Often	Every Day	Not Applicable
<b>Hypotension</b> (blood pressure $\leq 90/60$ mmHg)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Orthostatic Hypotension</b> (low blood pressure that happens when standing after sitting or lying down)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Fatigue / Weakness / Low Energy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Low Heart Rate</b> ( $\leq 50$ BPM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Light-Headed</b> (dizziness) / <b>Vertigo</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cold Extremities</b> (cold hands and feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dyspnea</b> (shortness of breath or difficulty breathing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Depression / Emotional Lability</b> (marked fluctuation in mood) / <b>Nightmares</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Decreased Libido</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nausea</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Additional questions:

1. Have you noticed any changes in your symptoms since your last medical visit?

Deterioration  Improvement  No change

• If there have been any changes in your symptoms, do you think these are related to:

Your medication (Specify): \_\_\_\_\_

Your condition (Specify): \_\_\_\_\_

Other (Specify): \_\_\_\_\_

2. Would you like to discuss your symptoms with your healthcare professional?

Yes  No

## To be completed by the healthcare professional

Have the symptoms been addressed with the patient?

Yes  No

• If yes, specify what actions have been taken:

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

TITRATION STATUS (Select only 1 per drug class)	MEDICATION CLASS				
	ACEi/ARB ARNI	Beta Blocker	MRA	SGLT2 inhibitor	If inhibitor
<b>No Indication</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Contraindicated</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason(s):	_____	_____	_____	_____	_____
<b>Not Tolerated</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason(s):	_____	_____	_____	_____	_____
<b>Ongoing Titration</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Maximum Tolerated Dose Achieved</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason for Suboptimal Dose:	_____	_____	_____	_____	_____
<b>Guidelines Target Dose Achieved</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Titration Completed</b>					
(dd/mm/yyyy)	_____	_____	_____	_____	_____

Additional Notes:

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