CollabCare

GOING FURTHER WITH
HEART FAILURE CARE

MY HEART FAILURE DIARY

to accompany you on your heart failure journey

CHFS/SCIC

Canadian Heart Failure Society
Société canadienne d'insuffisance cardiaque

MY HEART FAILURE DIARY

Name _____

Date of birth _____

Address _____

_____

_____

_____

_____

Telephone _____

Your health care team is at your disposal

YOUR MEDICAL CENTER

_____

YOUR CARDIOLOGIST

_____

YOUR GENERAL PRACTITIONER

_____

YOUR HEART FAILURE NURSE

_____

EMERGENCY NUMBER

_____

My heart failure treatments

Name and dosage of medicines (mg)				Comments

My other treatments

Name and dosage of medicines (mg)				Comments

Morning Noon Evening

MY PROFILE

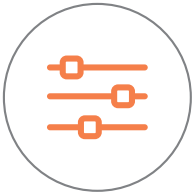
My weight

My usual/normal weight is between:

_____ and _____ ☐kg or ☐lb (check one)

It's important to check for swelling in your hands, ankles, legs, and around the waist by simply pressing your thumb into the tissue for a few seconds. If it leaves an indentation, you have swelling. This may indicate fluid retention, which can appear before you notice a marked difference in your weight.

Weight gain and adjustment of diuretic dosage



Excess fluid can be eliminated by temporarily/exceptionally increasing the dosage of diuretics for a short period, if your doctor has recommended this:

Extra diuretic prescribed _____

+ 1 kg _____ mg

+ 1.5 kg _____ mg

+ 2 kg _____ mg

Contact your doctor if you gain more than 2 kg in weight. Note: 1kg is equivalent to 2.2 lb.

MY PROFILE

My blood pressure

My normal blood pressure is between

_____ / _____ and _____ / _____ mm Hg

If your blood pressure is consistently higher than _____ * or lower than _____ *, or you have a headache, or feel dizzy or faint, discuss this with your doctor or nurse.

*as defined by your doctor

My heart rate

My normal heart rate is between _____ and _____ beats/min

If your heart rate is consistently higher than _____ * or lower than _____ *, or you feel dizzy or light-headed, or faint, discuss this with your doctor or nurse.

*as defined by your doctor

My INR (international normalized ratio)*

My INR is _____

* If you are taking an anticoagulant with antivitamin K activity

MY PERSONAL FOLLOW-UP

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		systolic	diastolic		Tiredness (YES or NO)	Breathlessness (YES or NO)	… hobbies & recreational activities	… your efficacy at work	… doing household chores	…visiting family or friends
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MY PERSONAL FOLLOW-UP

Questions to discuss with my doctor at the next visit

Tiredness _____

Average number of hours slept per night _____

Comfort level during sleep (e.g. how many pillows are needed to sleep comfortably, etc.) _____

_____

Breathlessness (cough) _____

Swelling _____

Loss of appetite _____

More frequent urination during the day: _____ During the night: _____

Limitations in my daily activities such as tiredness, mental capacity, concentration, inability to lift, walk etc

_____

Weight _____

Blood pressure _____

Heart rate _____

Other questions _____

_____

_____

MY NEXT APPOINTMENTS

Date	Time	Name of doctor/nurse/place	Notes
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___/___/___			
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CollabCare

MY HEART FAILURE DIARY

to accompany you on your heart failure journey

This document was created with input from members of the Global Heart Hub, Heart Failure Patient Council and HeartLife Foundation

Global HEART Hub
The Alliance of Heart Patient Organisations

HeartLife FOUNDATION

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