




Difficulty Breathing <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No If so where _____ Heart Rate _____ (BPM) Appetite <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No Weight (Lbs) _____ LBS Blood Pressure _____ Coughing / Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Liquid Consumed _____	Medication specific to treating Congestive Heart Failure					
	Amount Consumed _____		Generic Name	Brand Name	Strength Dose	Quantity Dose	How Often
	Liquid Consumed _____	<input type="checkbox"/> Lisinopril	Prinivil				
	Amount Consumed _____	<input type="checkbox"/> Ramipril	Altace				
	Liquid Consumed _____	<input type="checkbox"/> Quinapril	Accupril				
	Amount Consumed _____	<input type="checkbox"/> Enalapril	Epaned				
	Liquid Consumed _____	<input type="checkbox"/> Benazepril	Lotensin				
	Amount Consumed _____	<input type="checkbox"/> Fosinopril	Monopril				
	Notes	<input type="checkbox"/> Carvedilol	Coreg				
		<input type="checkbox"/> Metoprolol	Toprol				
<input type="checkbox"/> Nebivolol		Bystolic					
<input type="checkbox"/> Atenolol		Tenormin					
<input type="checkbox"/> Furosemide		Lasix					
<input type="checkbox"/> Bumetanide		Bumex					
	<input type="checkbox"/> Hydrochlorothiazide/HCTZ	Microzide					
	<input type="checkbox"/> Metolazone	Zaroxolyn					
	<input type="checkbox"/> Triamterene/HCTZ	Dyazide, Maxzide					
	<input type="checkbox"/>						


Sodium Log 

Breakfast- Food eaten _____ Amount _____ Sodium mg _____ | Snack- Food eaten _____ Amount _____ Sodium mg _____

Lunch - Food eaten _____ Amount _____ Sodium mg _____ | Snack- Food eaten _____ Amount _____ Sodium mg _____

Dinner - Food eaten _____ Amount _____ Sodium mg _____ | Snack- Food eaten _____ Amount _____ Sodium mg _____

Changes made:

A c t i v i t y L o g	What I did 	Total Minutes of Activity 	Total Steps per day 