# Prevention with Intention

**How do you evaluate a patient for heart disease?**

When we evaluate a patient, we first assess if a patient is at risk according to these factors:

- High blood pressure
- Diabetes
- Smoking
- Cholesterol levels
- Family history
- History of vascular disease

**What types of symptoms indicate a possible problem?**

- Chest symptoms which may feel like a pain, pressure, pushing or awareness that increases with activity and relieved with rest.
- Shortness of breath that is unexplained with activity, especially in women and the elderly.
- Other symptoms which are less common like dizziness, fatigue, swelling and stomach symptoms may indicate reason for concern.

**What do you do in a typical exam?**

- Check vital signs: "Vital signs are Vital!"
    - Blood Pressure: normal range 120/80
    - Heart Rate: normal range 60-100
    - Respiratory Rate: normal range 10-12
- Listen to the heart
    - Beats should be regular and consistent
    - Listen for abnormal sounds which we call murmurs.
    - Examine the neck - it is a fluid gauge. Listen in the neck for abnormal sounds which we call "bruits."
    - Look for swelling in the ankles (a possible indicator of heart failure) especially if it is "pitting" or leaves an indentation when you push on it.

**What is a common first test?**

- Talk with the patient about symptoms/history.
- Perform EKG or Electrocardiogram which examines the heart rate and patterns. Results can indicate heart disease and arrythmias (irregular heart beat).
- Evaluate blood work to look at electrolytes, blood counts, thyroid and cholesterol panels.

**What is the next step after evaluation?**

Get to know your body and "your goals" for blood pressure, cholesterol, and activity. Check your pulse regularly and blood pressure per your doctor's recommendations.