

The first step in diagnosing heart failure is a detailed medical history and a thorough physical examination. The results of this initial evaluation can help your doctor make a preliminary diagnosis to determine what tests are necessary to look at your heart function and confirm or rule out heart failure.

Click here http://www.pamf.org/forms/143952_Adult_Med_Hx.pdf for an example of a thorough medical history form like the one you may be asked to fill out.

What is a medical history?

A medical history is a catalogue of your symptoms, current and past health conditions, medications, and lifestyle choices. Your doctor will be looking for the presence of any health conditions (for example, [high blood pressure](#) , [diabetes](#) , [obesity](#) or [other heart conditions](#)) or behaviors (such as [smoking](#) or [excessive drinking](#)) that put you at high risk of developing heart failure.

She or he will also look for signs that something other than heart failure may be responsible for your symptoms: many of the [symptoms of heart failure](#) are common in other diseases including asthma, pneumonia, and lung disease.

Your doctor will ask about any symptoms you have been experiencing, including when you first had them, how often they occur, and how severe they are. You will also be asked a series of questions whether or not you are having any difficulty carrying out everyday activities like climbing a flight of stairs or carrying groceries. Your answers will help your doctor determine how much your symptoms are affecting your *functional capacity* (ability to perform basic physical tasks). Your symptoms will also be graded based on the New York Heart Association (NYHA) classification system, which ranks symptom severity from mild (Class 1) to severe (Class 4). The NYHA classification helps doctors decide the best course of treatment for you, how aggressively you should be treated, and evaluate your prognosis.

[Click here](#) for more information on the NYHA classification system.

You will be asked about any medical conditions or illnesses (for example, [coronary artery disease](#) or a [heart attack](#)) you currently have or have had in the past, as well as any surgeries or procedures you may have undergone. You should also provide your doctor with a detailed [family history](#) , particularly if heart attacks or heart muscle disease (*cardiomyopathy*) runs in your family.

¹
You will also need to provide a list of all the prescription and over-the-counter medications you are taking.

How does my medical history influence my heart failure diagnosis?

The more [heart failure symptoms](#) and risk factors you have, the greater the likelihood that heart failure explains the symptoms you have been experiencing. A medical history alone is never enough to diagnose heart failure, but provides a solid foundation for further investigation. A physical examination and diagnostic tests are still necessary to rule out other conditions and evaluate how your heart is functioning.

What does the physical examination for heart failure consist of?

The physical examination looks for signs of heart failure and its effects on your body. During the physical examination, the doctor will measure your pulse, temperature, blood pressure, and weight. Sudden weight gain (5 pounds or more in a week) may be a sign of fluid retention. The doctor will also check your abdomen, arms, and legs, as well as the veins in your neck for any signs of swelling that could be caused by fluid buildup related to heart failure.¹ Using a stethoscope, the doctor will listen to your chest for abnormal sounds in your heart (a rapid heartbeat or heart murmurs indicating faulty heart valves) and in your lungs (the crackling sound of fluid buildup).

There are many other possible causes for these signs and symptoms, especially shortness of breath. Your doctor may order one or more tests, including a [chest x-ray](#), [electrocardiogram](#) , and [echocardiogram](#)

, to check on your heart and lungs and confirm or rule out a diagnosis of heart failure.

Next Steps

The results of the medical history and physical examination help doctors decide which diagnostic tests are necessary to identify the cause of your symptoms and may provide clues to the treatment course that is likely to be most effective for you. The results of your initial medical history and physical exam will also serve as a "baseline" that can be compared with the results of later exams done throughout the course of your treatment. At later visits, your doctor will look for any changes in blood pressure, heart rate, and weight gain or swelling, and compare your current symptoms with your symptoms when you were first diagnosed. Any changes in these measurements or symptoms help doctors in determining how quickly your disease is progressing and how well your treatment plan is working.

References

1. Hunt SA. ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Update the 2001 Guidelines for the Evaluation and Management of Heart Failure). *J Am Coll Cardiol.* S2005;46(6):e1-82.

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