

Heart failure stoplight tool

Which zone are you in today: **green**, **yellow** or **red**?

Doctor/Provider: _____

Phone: _____



Green Zone

I'm feeling good.

- I do not have any shortness of breath.
- I am weighing myself daily.
- I have not gained more than 2 pounds in a week.
- I do not have any swelling in my feet, ankles, legs, or abdomen.
- I do not have chest pain.

How I'll prevent symptoms today

I will:

- Weigh myself first thing in the morning and write it down.
- Take my medicine as instructed.
- Check for swelling in my feet, ankles, legs, and abdomen.
- Eat low-salt food — follow a 2-gram per day sodium diet.
- Make sure to get enough activity and rest.



Yellow Zone

I'm not feeling good.

- I have had a weight gain of more than 2-3 pounds in one day or 5 pounds or more in one week.
- I have shortness of breath with my normal activities.
- I have swelling in my feet, ankles, legs, or abdomen.
- I feel more tired or have less energy than normal.
- I am having difficulty peeing.
- I am dizzy.
- I feel uneasy or a feeling something is not right.
- I have shortness of breath when lying down or need to sleep sitting up in a chair.

Caution!

Take action TODAY. I will:

- Report these symptoms to my doctor/provider without delay **AND**
- Continue to take my daily heart medications as prescribed **AND**
- Call my doctor/provider if my symptoms do not improve.

- _____
- _____
- _____



Red Zone

I feel awful!

- I am struggling to breathe.
- I have shortness of breath while sitting still.
- I am having chest pain.
- I feel confused or can't think clearly.

Get help!

Take action NOW:

- **CALL 911 or seek medical care RIGHT AWAY.**
- While getting help, do this:

- _____
- _____
- _____

Heart failure stoplight tool

Which zone are you in today: **green**, **yellow** or **red**?

Name: _____

My goal weight is: _____ Month: _____

(To be completed by care team)

Doctor/Provider: _____

Phone: _____

Tracking your weight and understanding the warning signs of congestive heart failure (CHF) are important to managing your health. Fill out this form daily to record your weight, answer whether you've taken your medicine, check for swelling, and determine your zone. Please have it with you for each visit with your care team. The back side explains the symptoms and warning signs for each zone.

Date	Weight	Medicine	Swelling	Zone
Day 1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 2		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 3		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 4		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 5		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 6		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 7		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 8		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 9		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 10		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 11		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 12		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 13		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 14		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 15		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	

Date	Weight	Medicine	Swelling	Zone
Day 16		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 17		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 18		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 19		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 20		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 21		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 22		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 23		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 24		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 25		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 26		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 27		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 28		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 29		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 30		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	
Day 31		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	