

Name: _____ Primary MD: _____

DOB: ___/___/___ Age: _____ Sex: M F Referring MD: _____ Date: ___/___/___

PATIENT TO FILL OUT

WHY ARE YOU HERE TO SEE THE HEART DOCTOR? (Other than being sent by your doctor. Be specific.) _____

Check if in the last 4 MONTHS you have had any of the following HEART SYMPTOMS:

- Chest pain or pressure
- Shortness of breath w/ activity
- Shortness of breath at rest
- Trouble breathing laying flat
- Waking up short of breath
- Leg pain when you walk
- Irregular or Rapid Heart Rhythm
- Fainting or Passing out
- Dizziness
- Blue lips or fingernails
- Swollen legs or arms
- Impotence

Check if you have ever had any of the following HEART PROBLEMS:

- Heart attack
- Abnormal EKG
- Heart failure
- Enlarged heart
- Heart Murmur
- Heart valve problem
- Birth defect of heart
- Stroke or mini-Stroke (TIA)
- Blocked heart arteries
- Blockages in leg arteries
- Aneurysm
- History of rheumatic fever

Check if you have any of the following RISK FACTORS for heart disease:

- Diabetes
- High blood pressure
- High cholesterol
- Smoking (Either Now or Previously)
- Close family member with blocked heart arteries, heart attack, or bypass before age 60?
- Close family member that died suddenly?
- High fat diet
- Overweight
- Lack of regular exercise
- Experienced menopause

Check if you have ever had any of the following CARDIOVASCULAR TESTS or PROCEDURES (include year done): Yes, but don't know details.

- _____ Stress Test or Nuclear Scan
- _____ Heart Ultrasound (Echo)
- _____ Carotid (Neck) Ultrasound
- _____ Cardiac MRI or CT
- _____ Holter Monitor
- _____ Electrophysiology Study
- _____ Ablation of rhythm problem
- _____ Pacemaker or Defibrillator
- _____ Heart cath/Angiogram
- _____ Angioplasty (balloon/stent)
- _____ Coronary Bypass Surgery
- _____ Valve Surgery

PAST MEDICAL AND SURGICAL HISTORY: Check YES or NO to each condition you have. Indicate date of surgery.

NO	YES	Condition	NO	YES	Condition	Date	Surgery	Details
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure	<input type="checkbox"/>	Appendectomy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	Back Surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Other Kidney / Bladder Problem	<input type="checkbox"/>	Eye Surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	COPD / Emphysema / Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Gallbladder Removal	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc	<input type="checkbox"/>	Hernia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestinal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Hysterectomy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Intestinal or Gastric Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Other Bone or Joint Problems	<input type="checkbox"/>	Lung Surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diverticular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Thyroid	<input type="checkbox"/>	Joint Replacement	_____
<input type="checkbox"/>	<input type="checkbox"/>	Colon Polyp	<input type="checkbox"/>	<input type="checkbox"/>	High Thyroid	<input type="checkbox"/>	Prostate Surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Bowel / Intestinal Problem	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Nodule	<input type="checkbox"/>	Thyroid Surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clot in Leg or Lung	<input type="checkbox"/>	Tonsillectomy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Liver Problem	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Tubal Ligation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	Other Surgery	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone						
<input type="checkbox"/>		Other Condition or Illness						



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REVIEW OF SYSTEMS: Check YES to **SYMPTOMS** experienced **IN THE LAST 4 MONTHS**. Check NO to symptoms not experienced.

Constitutional	NO YES	Genitourinary	NO YES	Endocrine	NO YES
Recurring Fever	<input type="checkbox"/> <input type="checkbox"/>	Frequent Urination at Night	<input type="checkbox"/> <input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/>
Excessive Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Men	NO YES	Excessive Urination	<input type="checkbox"/> <input type="checkbox"/>
Weight Gain	<input type="checkbox"/> <input type="checkbox"/>	Enlarged Prostate	<input type="checkbox"/> <input type="checkbox"/>	Hematologic / Lymphatic	NO YES
Weight Loss	<input type="checkbox"/> <input type="checkbox"/>	Women	NO YES	Prolonged Bleeding	<input type="checkbox"/> <input type="checkbox"/>
Eyes	NO YES	Excess Vaginal Bleeding	<input type="checkbox"/> <input type="checkbox"/>	Easy Bruising	<input type="checkbox"/> <input type="checkbox"/>
Cataracts	<input type="checkbox"/> <input type="checkbox"/>	Could you be pregnant?	<input type="checkbox"/> <input type="checkbox"/>	Allergic / Immunologic	NO YES
Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	Musculoskeletal	NO YES	Sinus Trouble	<input type="checkbox"/> <input type="checkbox"/>
Ears / Nose / Throat / Mouth	NO YES	Muscle aches	<input type="checkbox"/> <input type="checkbox"/>	Environmental Allergies	<input type="checkbox"/> <input type="checkbox"/>
Decreased Hearing	<input type="checkbox"/> <input type="checkbox"/>	Chronic Back Pain	<input type="checkbox"/> <input type="checkbox"/>	<div style="background-color: #cccccc; padding: 5px;"> <p align="center">DO NOT WRITE IN THIS AREA</p> <p><input type="checkbox"/> All other systems and unmarked items are negative.</p> <p><input type="checkbox"/> Patient was instructed to inform their primary care physician of non-cardiac symptoms.</p> </div>	
Nosebleeds	<input type="checkbox"/> <input type="checkbox"/>	Joint Pain or Swelling	<input type="checkbox"/> <input type="checkbox"/>		
Swallowing Problem	<input type="checkbox"/> <input type="checkbox"/>	Dermatologic	NO YES		
Respiratory	NO YES	Rash	<input type="checkbox"/> <input type="checkbox"/>		
Cough	<input type="checkbox"/> <input type="checkbox"/>	Hair loss	<input type="checkbox"/> <input type="checkbox"/>		
Cough Blood	<input type="checkbox"/> <input type="checkbox"/>	Neurologic	NO YES		
Wheezing	<input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/>		
Gastrointestinal	NO YES	Seizures	<input type="checkbox"/> <input type="checkbox"/>		
Nausea	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric	NO YES		
Abdominal Pain	<input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>		
Blood In Stool	<input type="checkbox"/> <input type="checkbox"/>	Chronic Anxiety	<input type="checkbox"/> <input type="checkbox"/>		
Black or Tarry Stools	<input type="checkbox"/> <input type="checkbox"/>	Claustrophobia	<input type="checkbox"/> <input type="checkbox"/>		
Constipation	<input type="checkbox"/> <input type="checkbox"/>				
Diarrhea	<input type="checkbox"/> <input type="checkbox"/>				

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SOCIAL HISTORY:

What is your **MARITAL STATUS**?

- Widowed Single (never married) Homosexual
 Divorced Married Other
 Separated Spouse's Name: _____

Do you have **CHILDREN**? If yes, how many Sons: _____ Daughters: _____

With whom do you live? _____

WORK AND MILITARY HISTORY:

Are you working? No Yes, **EMPLOYER:** _____

If not working: Retired Disabled Unemployed

What is/was your **OCCUPATION**? _____

Have you served in the **MILITARY**? Yes No

If yes, what branch? _____

HEALTH HABITS:

Do you **SMOKE** or chew tobacco? Yes No No, but I used to

Age when started? _____ Packs a day smoked? _____

Ever tried to quit? Y N Age when quit? _____ Want to quit? Y N

Do you drink **ALCOHOL**? Yes No No, but I used to

How much? _____ When did you quit? _____

Do you use **RECREATIONAL or IV DRUGS**? Yes No

How many **CAFFEINATED BEVERAGES** do you have a day? _____

Do you **EXERCISE** at least 3 times a week? Yes No

If not, why? _____

DIET: Regular Low salt Low cholesterol Diabetic Vegetarian

ALLERGIES

Do you have any **DRUG ALLERGIES**? Yes No

List them: _____

Are you allergic to **IODINE**, contrast dye, shrimp, or shellfish? Yes No

FAMILY HISTORY: Not known Adopted or Orphan

Father's age _____, or age at death _____, cause of death _____.

Mother's age _____, or age at death _____, cause of death _____.

How many brothers do you have living? _____ Deceased? _____

How many sisters do you have living? _____ Deceased? _____

What medical conditions run in your family. Check each that applies.

	Father	Mother	Sibling	Child
Heart Attack				
Angina				
Heart Failure				
Rhythm Problem				
Died Suddenly				
Stroke				
Diabetes				
High Blood Pressure				
High Cholesterol				
Cancer				

Other family with heart problems. (Ex: Paternal uncle, age 55, pacemaker)
