Date Seen: _____

Name: _____ DOB_____ MR#_____ Sex: ____

What is the name of the doctor who referred you to us? _____Name of your family M.D. _____

WHY ARE YOU HERE to see a Cardiology heart doctor? _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

Mark X on any HEART PROBLEMS or SYMPTOMS:

- □ Chest pains or pressure
- □ Angina
- □ Heart attack
- □ Heart failure
- □ Enlarged heart
- □ Abnormal rhythm arrhythmias
- □ Palpitations/Irregular heart beat
- □ Heart murmur
- □ Blue lips or fingernails
- □ Shortness of breath
- □ Dizziness
- □ Fainting
- □ Leg cramps when you walk
- □ Swollen legs

Please mark X if you have:

Ever smoked? □ Yes □ No Year Quit _____ Packs per day _____

□ Diabetes □ High blood pressure □ Overweight □ High triglycerides

□ High cholesterol: Total_____ LDL_____ HDL_____ Trig_____

For woman only: Could you be pregnant? □ Yes □ No

Have you passed menopause / change of life? □ Yes □ No

At what age? _____ Do you take estrogen? _____

Has a close family member had: Mother – Father – Sibling			Age Occurred	Cause of Death
A heart attack?	□ Yes	□ No	_____	□
Angina?	□ Yes	□ No	_____	□
Bypass surgery?	□ Yes	□ No	_____	□
Carotid surgery?	□ Yes	□ No	_____	□
Surgery of leg arteries?	□ Yes	□ No	_____	□

Mark X if you have ever had any of the following PROCEDURES: Indicate approximate year of the procedure

- □ Stress test _____
- □ Coronary bypass surgery _____
- □ Valve surgery _____
- □ Electrocardiogram_____
- □ Electrophysiology Study or Procedure _____
- □ Cardiac catheterization / Heart catheterization _____
- □ Pacemaker or Defibrillator _____
- □ Coronary Angioplasty balloon arthrectomy / stent _____

Please list all illnesses you are being treated for now or have you been treated for. Please include date or year

1. _____ 3. _____
2. _____ 4. _____

Please list all injuries or surgeries you have had. Please include date or year

1. _____ 3. _____
2. _____ 4. _____

Social History:

MARITAL STATUS: □ Single □ Married □ Separated □ Divorced □ Widowed

Spouse name _____

CHILDREN: □ Yes □ No # of Sons _____ # of Daughters _____

OCCUPATION: _____

MAJOR HOBBY: _____

DIET: □ Regular □ No Added Salt □ Low Salt □ Low Fat / Chol □ Diabetic

□ Other: _____

ALCOHOL USE: □ Yes □ No □ Former Year Quit _____

□ Rarely □ Frequently □ Socially □ Occasionally □ Daily

EXERCISE: □ Sedentary □ Occasionally □ Regularly □ Active Lifestyle □ Physically Unable

Cardiac Hx

☐ CAD ☐ CHF/CM

☐ Arrhythmia ☐ PVD

☐ ValveCongen ☐ Other

HPI

Onset: _____

Frequency: _____

Location: _____

RiskFx

Procedures

PMH

Social Hx Family Hx

☐ **EMR**