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Background

Name _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____

Marital status: [] Married [] Divorced [] Widowed [] Single [] Other: _____

[] Retired Most Recent/Current Occupation: _____ Exercise: _____

Cardiac Risk Factors (Check all that apply)

[] Hypertension (high blood pressure) [] Diabetes [] High Cholesterol [] Overweight/Obesity

Tobacco (packs per day): [] Never [] <1/2 [] 1/2-1 [] 1-2 [] >2 [] Quit Smoking Date: _____

Alcohol (drinks per day): [] None [] <1 [] 1-2 [] 2-3 [] >3 [] Quit Alcohol Date: _____

Caffeine (drinks per day): [] None [] <1 [] 1-2 [] 2-4 [] >4

Personal Past Cardiac History (Check all that apply)

[] Coronary Artery Disease [] Myocardial Infarction (Heart Attack) [] Angina

Most Recent Heart Catheterization (Date & Hospital): _____

[] Coronary Stent (Dates) _____ [] Angioplasty (Dates) _____

[] Cardiac Bypass Surgery (Date) _____ [] Last Stress Test (Date/Place) _____

[] Congestive Heart Failure Last Hospitalization for Heart Failure (Date & Hospital): _____

Most Recent Echocardiogram (Date & Location): _____ Ejection Fraction: _____

[] Peripheral Vascular Disease [] Stroke [] Transient Ischemic Attack (Mini Stroke) [] Carotid artery disease

[] Abdominal Aortic Aneurysm [] Leg Claudication (Pain with walking)

[] Vascular Surgery (type, date, place) _____

Other: _____

Valvular Heart Disease Aortic Valve: [] Stenosis [] Regurgitation

Mitral Valve: [] Prolapse [] Regurgitation [] Stenosis [] Rheumatic Fever

[] Valve Surgery (Type of Valve, Date, Hospital): _____

Other: _____

Heart Rhythm Disorder [] Palpitations [] Atrial Fibrillation [] Atrial Flutter [] WPW

[] Heart Block [] Syncope (passing out) [] Pacemaker (Type, date) _____

[] Ablation Procedure (Type, Date & Hospital): _____

Other Cardiac Disease [] Myocarditis [] Pericarditis [] Pericardial Effusion [] Pulmonary Hypertension

[] Other: _____

Personal Past Medical History (Please check conditions currently treated or treated in the past)

- Lung disease:** Asthma COPD or emphysema Sarcoid disease
 Sleep Apnea CPAP use Pneumonia
- Neurological diseases:** Migraine headaches Seizure disorder Neuropathy
- Liver disease:** Hepatitis Liver failure (cirrhosis) Gallstones
- Gastrointestinal disease:** Gastroesophageal reflux disease (heartburn) Peptic ulcer disease
 Chronic diarrhea Constipation Irritable bowel syndrome
- Kidney disease:** Renal failure Hemodialysis or Peritoneal dialysis
- Autoimmune disease:** Osteoarthritis Gout Rheumatoid arthritis Lupus arthritis Scleroderma
 Immune deficiency (HIV, AIDS, or other)
- Hematologic disease:** Anemia Bleeding disorder Deep vein thrombosis (DVT) Pulmonary embolus (PE)
- Oncologic disease:** Cancer (type) _____
Cancer treatments: Chemotherapy Radiation Surgery
- Endocrine disease:** Thyroid disease Cushing's disease Addison's disease
- Ophthalmologic disease:** Glaucoma Cataracts Macular degeneration
- Psychiatric:** Depression Anxiety Other: _____

Other Personal Medical History

Personal Past Surgical history (Please list type of surgery, approximate year)

- Gallbladder _____ Appendix _____ Tonsils _____ Hernia _____

<i>Surgery</i>	<i>Year</i>	<i>Surgery</i>	<i>Year</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies: _____

Current Medications You may attach a separate list. Include herbal remedies, aspirin, and vitamin supplements.

<i>Medication</i>	<i>Dose</i>	<i>How often</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History (Please list immediate family members – parents, siblings, children)

	Deceased	Age (if deceased, age at death)	Heart attack	Heart Failure	Heart Bypass Surgery	Hypertension	Stroke	Other
Father	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of symptoms: Please check any symptoms you have had in the past 3 months

- | | | |
|--|---|---|
| <p><u>General:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Change in appetite <input type="checkbox"/> Persistent fever <input type="checkbox"/> General fatigue <input type="checkbox"/> General weakness <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Sensitivity to heat <input type="checkbox"/> Sensitivity to cold <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <p><u>Eyes:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Loss of vision <input type="checkbox"/> Dry eyes <p><u>Ears, nose, mouth, throat:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Dentures <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness | <p><u>Cardiovascular:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Palpitations <input type="checkbox"/> Fainting/loss of consciousness <input type="checkbox"/> Blue fingers or lips <input type="checkbox"/> Varicose veins <p><u>Respiratory:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Persistent cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Pain with breathing <input type="checkbox"/> Short of breath laying down <p><u>Endocrine:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Adrenal disease <input type="checkbox"/> Cortisone treatment <p><u>Genitourinary:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent daytime urination <input type="checkbox"/> Frequent nighttime urination <input type="checkbox"/> Pain or burning with urination <input type="checkbox"/> (men) erectile dysfunction <p><u>Nervous system:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Lightheadedness/dizziness <input type="checkbox"/> Memory loss <input type="checkbox"/> Weakness or paralysis | <p><u>Gastrointestinal:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Tarry stools <input type="checkbox"/> Jaundice <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Difficulty swallowing <p><u>Skin:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash <input type="checkbox"/> Loss of pigmentation <input type="checkbox"/> Itching <input type="checkbox"/> Dry skin <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Skin Ulcers <p><u>Musculoskeletal:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Pain in joints <input type="checkbox"/> Swollen joints <input type="checkbox"/> Stiffness |
|--|---|---|