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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
- Neurologic diseases:**  Migraine headaches  Seizure disorder
- 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  Rheumatoid arthritis  Lupus arthritis  Scleroderma  
 Immune deficiency (HIV, AIDS, or other)
- Hematologic disease:**  Anemia  Bleeding disorder
- 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>unit (mg)</i>	<i>How often</i>	<i>Comment</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

	Yes
<b>General:</b>	
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	<input type="checkbox"/>

<b>Eyes:</b>	
Blurry vision	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>

<b>Ears, nose, mouth, throat:</b>	
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	<input type="checkbox"/>

<b>Cardiovascular:</b>	Yes
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	<input type="checkbox"/>

<b>Respiratory:</b>	
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	<input type="checkbox"/>

<b>Endocrine:</b>	
Adrenal disease	<input type="checkbox"/>
Cortisone treatment	<input type="checkbox"/>

<b>Genitourinary:</b>	
Frequent daytime urination	<input type="checkbox"/>
Frequent nighttime urination	<input type="checkbox"/>
Pain or burning with urination	<input type="checkbox"/>
(men) erectile dysfunction	<input type="checkbox"/>

<b>Nervous system:</b>	
Headaches	<input type="checkbox"/>
Lightheadedness/dizziness	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>
Weakness or paralysis	<input type="checkbox"/>

<b>Gastrointestinal:</b>	Yes
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	<input type="checkbox"/>

<b>Skin:</b>	
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	<input type="checkbox"/>

<b>Musculoskeletal:</b>	
Muscle cramps	<input type="checkbox"/>
Pain in joints	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>