



Name: _____ DOB: _____ Date: _____

Main reason/concern for today's visit:				
Please Check if you have had any of the following symptoms.		Have you had any of the following procedures?	When	Where
Chest pain / Pressure / Tightness		EKG		
Shortness of breath with activity		Chest X-Ray		
Shortness of breath lying down		Echocardiogram		
Ankle swelling		Nuclear Stress Test		
Heart racing / Fluttering		Holter Monitor		
Passing out (fainting)		Heart Cath / Arteriogram		
Almost passing out		Heart PTCA / Balloon / Stent		
Weight gain / loss		CABG/Bypass/Heart Valve Surgery		
Leg pain		EP Study		
Fatigue		Pacemaker Implant - Type?		
Change in appetite				
Cough / Wheezing		Defibrillator		
Dizziness		Tilt Study		
Headaches				
Numbness / Weakness				

Review of Systems							
Have you had any of the following?		YES	NO			YES	NO
General	Unexplained Fever			GU	Kidney Stones		
	Headache/Migraines				Painful or bloody urination		
					Are you pregnant?		
Cardiovascular	Atrial Fibrillation				Impotence/Sexual Problems		
	Congestive Heart Failure CHF				Kidney Problems		
	Heart Attack				Prostate Problem		
	Heart Rhythm Problem				Urinary tract infection		
	Hypertension (High BP)						
	Increased Cholesterol			Skin	Rash		
	Murmur or Valve Problem				Itching		
	Rheumatic Fever as a child				Varicose Veins		
	Other Vascular Problems				Skin Issues		

Have you had any of the following?		YES	NO			YES	NO
<u>HEENT</u>	Eye Disease			<u>MS</u>	Joint Pain		
	Glaucoma				Muscle or Joint Weakness		
	Cataracts				Muscle Pain or Cramps		
	Hearing Loss				Back Pain		
	Hearing Aids (r, l, bilateral)				Cold Extremities		
	Sinus Problems				Arthritis		
	Nose Bleed						
	Bleeding Gums			<u>Psych</u>	Depression or Anxiety		
	Glasses/Contacts				Seizures		
					Insomnia		
<u>Respiratory</u>	Spitting Up Blood				Panic Attacks		
	Emphysema						
	Cough			<u>Neuro</u>	Frequent Headaches		
	Asthma				Numbness or Tingling		
	Wheezing				Weakness on one side		
	Chronic Lung Disease				Tremor		
	Do you have an inhaler				Difficulty speaking		
	Are you on home oxygen				Head Injury		
	Have you had a TB Test				Stroke		
	Was TB test Normal				Vertigo		
	Pneumonia - When?						
				<u>Endo/Hemo</u>	Thyroid Problem		
<u>GI</u>	Nausea/Vomiting				Other hormone problem		
	Frequent Diarrhea				Heat/Cold Intolerance		
	Constipation				Bleeding		
	Hepatitis				Easy Bruising		
	Bloody Stools				Anemia		
	Indigestion				Blood transfusions		
	Stomach Ulcers				HIV		
	Acid Reflux				Blood clots		
	Colitis				B-12 deficiency		
	Diverticulitis/culotis				Cancer - Type?		
	Gallbladder Disease				Diabetes - on insulin?		
	Irritable Bowel Syndrome IBS				Lupus		
	Ulcers/Bleeding Ulcers				Lymphoma		
	Pancreatitis			Extremities	Blood clot in leg		
					Leg pain while walking		

Personal Habits		
<u>Cigarettes/Tobacco</u> Have you ever smoked? Y N If yes, when quit? _____ How many packs a day did you smoke: _____ How many years did you smoke: _____	<u>Alcohol</u> Do you drink now? Y N If yes, how many drinks per day: _____ How many days per week: _____ If no, how long ago did you quit? _____	<u>Substance Abuse</u> Have you ever had or do you currently have a substance abuse problem? Y N If yes, what type of drug and frequency of use:

Caffeine Intake		
Coffee _____ cups per day	Tea _____ cups per day	Canned Soda _____ cups per day

Hospitalizations/Major Illnesses	When/Where	Surgeries	When/Where

Medication Allergies	Type of Reaction
Do you have an allergy to Iodine? YES NO	Do you have an allergy to shrimp or shellfish YES NO
Do you have an allergy to Dye or Contrast? YES NO	

Family History - List current age or age at death below		Health problems such as heart probs, high BP, diabetes, high cholesterol, stroke, cancer, etc	Provider Comments
Father Age:	Alive or Deceased		
Mother Age:	Alive or Deceased		
Brother(s) - #	Alive or Deceased		
Age:	Alive or Deceased		
Age:	Alive or Deceased		
Sister(s) - #	Alive or Deceased		
Age:	Alive or Deceased		
Age:	Alive or Deceased		
Children - #	Alive or Deceased		
M F Age:	Alive or Deceased		
M F Age:	Alive or Deceased		

