Name:______________________________

Date of Birth: ______________________________

Chart #:______________________________

CARDIOLOGY

Primary Care Doctor: ______________________________

Other Doctors: ______________________________

Referred By: Primary Care Doctor: ☐ Specialist: ☐ ER Doctor: ☐ Self Referred: ☐

Main Reason for Today's Visit:

Shortness of Breath	☐	Swelling	☐
Palpitations	☐	Abnormal EKG	☐
Chest Pain	☐	Atrial Fib	☐
Dizziness/Fainting	☐	Pre-Op Clearance	☐
Arm/Jaw Pain	☐	Other	☐

General

Tobacco (circle all that apply) Cigarettes, Cigars, Pipes, Chew	Currently Use: ☐ Yes ☐ No Amount (per day):	Former Use: ☐ Yes ☐ No

	Yes	No
Diabetes	☐	☐
Hypertension	☐	☐
High Cholesterol	☐	☐
Family Heart Disease:	☐	☐

If Yes:

☐ **Mother (Age when diagnosed)** ______

☐ **Father (Age when diagnosed)** ______

☐ **Siblings (Age when diagnosed)** ______

Have you ever had:	**Yes**	**No**
Stress Tests	☐	☐

Have you ever had:	**Yes**	**No**
Heart Attack	☐	☐

If Yes, When______________________

Treatment______________________

	Yes	No
Coronary Disease	☐	☐
Stent	☐	☐
Bypass Surgery	☐	☐
Murmur	☐	☐
Leaky Valve	☐	☐
Rheumatic Fever	☐	☐
Valve Surgery	☐	☐

If Yes, Please Mark Type of Valve:

Porcine ☐ Bovine ☐ Mechanical ☐

Aortic ☐ Mitral ☐

	Yes	No
Pacemaker	☐	☐

Brand ______________________

	Yes	No
Defribillator	☐	☐

Brand ______________________

	Yes	No
Leg Swelling	☐	☐

	Yes	No
Leg Pain/Cramps	☐	☐
History of DVT (Clotting in Legs)	☐	☐
Claudication/ Peripheral Vascular Disease	☐	☐

	Yes	No
Stroke/Mini Stroke	☐	☐

If Yes, did you experience:

Unusual Headache	☐	Numbness/Tingling	☐
Left or Right Weakness	☐	Paralysis	☐
Speaking problem	☐		
Partial Blindness	☐		
Double Vision	☐		

	Yes	No
Seizures	☐	☐

	Yes	No
Hearing Problems	☐	☐

If Yes, which ear: ☐ **Right Ear** ☐ **Left Ear**

Nasal Problems	☐	☐
Oral Problems	☐	☐
Swallowing Difficulty	☐	☐
Ringing in the Ears	☐	☐
Thyroid Problems	☐	☐

	Yes	No
Weight Gain	☐	☐
Weight Loss	☐	☐
Fever	☐	☐

	Yes	No
Glaucoma	☐	☐
Cataracts	☐	☐
Retina Problems	☐	☐

Chest	**Yes**	**No**
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Coughing up Blood	☐	☐
COPD	☐	☐

GI	**Yes**	**No**
Vomitting Blood	☐	☐
Black Stools	☐	☐
Bloody Stools	☐	☐
Bright Red Blood per Rectum	☐	☐
History of Heartburn	☐	☐
Ulcers	☐	☐

Liver	**Yes**	**No**
Yellow Jaundice	☐	☐
Gallstones	☐	☐
Hepatitis	☐	☐
Pancreas Trouble	☐	☐

Kidney	**Yes**	**No**
Kidney Failure	☐	☐
Blood in Urine	☐	☐
Pain w/Urinating	☐	☐
Kidney Stones	☐	☐
Gout	☐	☐

Females	**Yes**	**No**
Breast Lumps	☐	☐
Gynecological Problems	☐	☐

Males	**Yes**	**No**
Enlarged Prostate	☐	☐
Prostate Cancer	☐	☐

Name:

Date of Birth:

Chart #:

CARDIOLOGY

Joints & Muscles	Yes	No	Blood Disorders	Yes	No	Pshychological	Yes	No	Other
Arthritis	☐	☐	Easy Bruising	☐	☐	Depression	☐	☐	**Other Chronic Medical Problems:**
Neck Pain	☐	☐	Excessive Bleeding	☐	☐	Anxiety	☐	☐	
Back Pain	☐	☐	Platelet Problems	☐	☐	Panic Attacks	☐	☐	
Spinal Stenosis	☐	☐	Bleeding Gums/Nose	☐	☐	Drug Addiction	☐	☐	
Injuries	☐	☐	Anemia	☐	☐	Alcoholism	☐	☐	
Hip Replacement	☐	☐				Bipolar Disorder	☐	☐	
Knee Replacement	☐	☐				Schizophrenia	☐	☐	

OPERATIONS (List All Surgeries Along with Year of that Surgery)

Surgery:	Year:

Alcohol Beer Wine Liquor	Currently Use: Yes No Amount (per day):	Former Use: Yes No
Illicit Substances Heroin Cocaine Marijuana Other	Currently Use: Yes No Amount (per day):	Former Use: Yes No
Caffeine	Currently Use Coffee: Yes No Amount:	Currently Use Soda: Yes No Amount:
Diet - Salt Intake Low Moderate High	Fat Intake Low Moderate High	Sugar Intake Low Moderate High
Exercise Yes No If Yes, Type:	How Long Min.	How Often /Week

Current Medications

Name / Dose / Times Per Day		Name / Dose / Times Per Day	
	1/d 2/d 3/d 4/d 5/d		1/d 2/d 3/d 4/d 5/d
	1/d 2/d 3/d 4/d 5/d		1/d 2/d 3/d 4/d 5/d
	1/d 2/d 3/d 4/d 5/d		1/d 2/d 3/d 4/d 5/d
	1/d 2/d 3/d 4/d 5/d		1/d 2/d 3/d 4/d 5/d
	1/d 2/d 3/d 4/d 5/d		1/d 2/d 3/d 4/d 5/d
	1/d 2/d 3/d 4/d 5/d		1/d 2/d 3/d 4/d 5/d

Drugs or Substances (Including IV (Iodine) Dye) You Are Allergic or Intolerant Of

Drug or Substance	Reaction

Iodine/X-Ray Dye Allergy Yes ☐ No ☐

Other Information

Married: ______ **Single:** ______ **Divorced:** ______ **Widowed:** ______

Children: ______ **Males:** ______ **Females:** ______ **Ages:** ______

Occupation: ______ **Retired:** ☐ Yes ☐ No

Guardian/Next of Kin: Name: ______

Relationship: ______

Patient Signature: ______

Date: ______