



Appt. Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Age _____ Date of Birth _____

SS# _____ Medicare# _____ Medicaid# _____

Do you have a Second Address & Phone#? _____

Employer/Address _____

Spouse's Employer/Address _____

Emergency Contact Name _____ Phone _____

Insurance

#1

Primary Insurance

Name _____

Address _____

Policy # _____ Group# _____

Are you the Policy Holder? yes _____ no _____ If no:

Name of Policy Holder _____

#2

Secondary Insurance

Name _____

Address _____

Policy# _____ Group# _____

Are you the Policy Holder for 2nd Insurance? yes _____ no _____ If no:

Name of Policy Holder _____

Reason for Today's Visit? _____

PAST MEDICAL HISTORY:

Please list any previous illness, hospitalizations or surgeries, and the year:

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

Please list any medications you are currently taking:

name, strength, frequency

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Please List Allergies or Sensitivities to Medications or X-ray Dye Reaction:

Have you seen a cardiologist in the past? If "yes":

Name _____ Location _____

Have you been told you have:

Angina, Mitral Valve Prolapse, Heart Murmur, TIA's, Diabetes, High Blood Pressure, Heart Attack (circle) Date _____.

Have you ever had any of the following procedures? Please tell us when.

Heart Catheterization _____ Angioplasty _____

Coronary Bypass _____ Exercise Test _____

Echocardiogram _____ Holter Monitor _____

Do you know your cholesterol level? _____.

Family History

Living	Age	Health Status
Father		
Mother		
Sisters		
Brothers		

Deceased	Age at Death	Cause of Death
Father		
Mother		
Sisters		
Brothers		

Do you have a family history of? (circle)

Diabetes High Cholesterol Stroke Cancer Heart Attack

Social History

Are you: Married Single Divorced Widowed

Number of Children? _____ Ages _____

Do you smoke? yes ____ no ____ How much _____ How long _____ Year Quit _____

Do you drink alcohol? yes ____ no ____ How much per week? _____

Do you exercise? yes ____ no ____ What do you do? _____

Frequency _____

Please circle if it applies to you.

Eyesight: Good - Fair - Poor - Glaucoma

Ears, Nose, Throat: Poor Hearing - Sore Throat - Sinus Problems

Gastrointestinal: Swallowing problems - Indigestion - Ulcers
Hiatal hernia - Bloody stools - Diarrhea

Genitourinary: Difficulty Urinating - Blood in Urine - Prostate problems
Kidney problems - Postmenopausal

Musculoskeletal: Muscle pain - Joint pain - Arthritis

Integumentary: Skin rash - skin disorders

Neurological/Psychiatry: Fainting - Depression - Anxiety - Drug Dependence

Endocrine: Thyroid disease - Diabetes

Hematologic/Lymphatic: Taking blood thinners - Taking aspirin - Coumadin

Allergic/Immunologic: Sinusitis - Hayfever - Allergies

****Please answer the questions in the following sections, if they apply to you****

Chest Pain

Do you have Chest Pain? yes _____ no _____ If *yes* answer questions 1-9.
If *no* move to the next section.

1. How long have you had chest pain? _____
2. Location of chest pain? _____
3. Radiation of chest pain: none, left arm, left shoulder, right arm,
right shoulder, jaw, back (circle)
4. Character of pain: dull, pressure, heaviness, sharp (circle)
5. Duration of episodes: seconds, minutes, hours, constant (circle)
6. Severity of pain 0-10 (zero being pain free) _____
7. Do you have pain with: exercise, resting or both? (circle)
8. Do you have any of the following with your pain? shortness of breath, nausea,
palpitations or sweating (circle)
9. Are any of these symptoms relieved with nitroglycerin? yes _____ no _____

Shortness of Breath

Do you have shortness of breath? yes ____ no ____ If *yes* answer questions 1-9.
If *no* move on to the next section.

1. How long have you had shortness of breath? _____
2. What makes you short of breath? _____
3. Do you wake up at night short of breath? never, rarely, every night (circle)
4. Do you get up to urinate at night? yes ____ no ____
5. Do you tire easily? yes ____ no ____
6. Do you have leg or ankle swelling? yes ____ no ____
7. Do you have wheezing? yes ____ no ____
8. Do you have a cough? yes ____ no ____ Sputum production? yes ____ no ____

Palpitations

Do you have palpitations? yes ____ no ____ If *yes* answer questions 1-5.
If *no* move on to the next section.

1. How long have you had palpitations? _____
2. Does your heart feel like: skipping beats, racing, beating fast & regular,
beating fast & irregular? (circle)
3. Do your palpitations occur with any of the following: rest, exercise, excitement
alcohol, caffeine? (circle)
4. Are you under a lot of tension and stress? yes ____ no ____
5. Do you have other symptoms with your palpitations? none, dizziness, fainting,
shortness of breath,
nausea, sweating,
lightheadedness (circle)

Patient Signature: _____ Date: _____

PHYSICIAN SIGNATURE: _____