PLEASE PROVIDE A LIST OF CURRENT MEDICATIONS TO THE FRONT OFFICE.

Why are you here to see a cardiologist and what type of heart problems are you having?

_____

_____

Check off any heart problems or symptoms:

- ☐ Heart attack
- ☐ Angina
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Abnormal rhythm (arrhythmia)
- ☐ Palpitations, irregular heartbeats
- ☐ Fainting
- ☐ Enlarged heart
- ☐ Chest pains or pressure
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Swollen legs
- ☐ Heart failure
- ☐ Blue lips of fingernails
- ☐ Leg cramps when you walk

Have you ever had: If so, ***when*** and by ***whom***

- ☐ Stress Test _____
- ☐ Echocardiogram _____
- ☐ Cardiac Catheterization/Heart Catheterization

_____

- ☐ Coronary Angioplasty (balloon)

_____

- ☐ Coronary Bypass Surgery (open heart)

_____

- ☐ Valve Surgery _____
- ☐ Electrophysiology Study or Procedure

_____

- ☐ Pacemaker or Defibrillator

Tell us about your risk of heart disease.
Please check if you have:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes

If you are a woman, have you passed menopause (change of life?)_____ At what age? _____

Please tell us anything else concerning your heart:

_____

_____

Are you being treated now or have been treated for any illness?

1. _____
2. _____

Are you allergic to any medication? _____
List medications and the reaction you had:

1. _____
2. _____

Have you had any operations? / ıjuries? If so, ***when*** and ***where***.

1. _____
2. _____

Have you ever been hospitalized? Please list ***hospitals*** and ***date***.

1. _____
2. _____

Check if any close family members (parents, siblings, children) have and ***when***: Please list family member, age of family member and alive or deceased.

- ☐ Heart problems _____
- ☐ High blood pressure _____
- ☐ Diabetes _____
- ☐ Cancer _____

Are there any other health problems in your family? If so, who, ***type*** and ***when***: _____

_____

With whom do you live? _____

Occupation: _____

Educational level: _____

Health Habits:
Do you smoke? ☐ Yes ☐ No If yes, packs per day? _____
For how many years? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much _____ how often?_____

Do you drink caffeine? ☐ Yes ☐ No
If yes, type _____ how much? _____

Do you drink energy drinks? ☐ Yes ☐ No

Are you currently taking diet pills? ☐ Yes ☐ No

Do you use illicit (illegal) drugs? ☐ Yes ☐ No

Do you take herbal or vitamin supplements? ☐ Yes ☐ No
Type? _____

Please circle any present symptoms.

Lack of appetite; trouble sleeping; loss of appetite; weight changes; fevers
Eye problems; such as double or blurred vision; glaucoma; cataracts
Hearing problems; buzzing or ringing in ears
Allergies; hay fever; sinus problems
Breathing problems; wheezing; cough; coughing blood; asthma; tuberculosis
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones
Urinary problems; frequency; infections; stones; bladder Men: prostate problems; night-time urination Women: abnormal menstrual periods. Could you be pregnant?
Joint pains; swelling or redness; arthritis; back pain; muscle aches or tenderness; gout
Rash; itching or other skin problems
Women: breast lumps, recent mammogram, pap smear and/or pelvic exam
Paralysis (even temporary); stroke; numbness; loss of balance; seizures; loss of memory; headaches; unusual thoughts; nervousness; crying of sadness; depression; suicide attempts
Thyroid disorder; diabetes; excess thirst; hunger or urination; bleeding; easy bruising; risk factors for HIV; anemia; cancer