

CARDIAC RISK FACTORS

Please check appropriate box as it applies to YOU

History of tobacco use	<input type="checkbox"/> yes	<input type="checkbox"/> no	History of heart attack or blocked arteries	<input type="checkbox"/> yes	<input type="checkbox"/> no
Parents or sibling(s) with history of heart attack or blocked arteries	<input type="checkbox"/> yes	<input type="checkbox"/> no	History of obesity	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have a history of high cholesterol	<input type="checkbox"/> yes	<input type="checkbox"/> no	Sedentary (not active) lifestyle	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have a history of high blood pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	Are you a male over 45 or a female over 55?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have a history of diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	If female, have you experienced menopause	<input type="checkbox"/> yes	<input type="checkbox"/> no

PAST MEDICAL HISTORY

Please check appropriate box as it applies to YOU

<p>Past Medical Illnesses</p> <p>Asthma <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Chronic bronchitis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Emphysema or COPD <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cancer <input type="checkbox"/> yes <input type="checkbox"/> no If yes, type _____</p> <p>Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no Insulin dependent, diet, medications <i>(please circle)</i></p> <p>Kidney stones <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Kidney failure <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Liver problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Gallbladder Problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Peptic Ulcer <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>GERD <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Prostate problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Rheumatic Fever <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Seizures <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Sleep Apnea <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Stroke <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Mini-strokes (TIA) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Thyroid Disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>INFECTIOUS DISEASE</p> <p>Hepatitis B <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Hepatitis C <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>HIV <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>MRSA <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>VRE <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>Past Cardiac Problems</p> <p>Angina/Chest Pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Atrial Fibrillation <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Congestive heart failure (CHF) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Coronary artery disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Enlarged Heart <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Attack (MI) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Murmur <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>High Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>High Cholesterol <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Irregular heartbeat (arrhythmias) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Mitral Valve prolapse <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Valve problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Peripheral Vascular Disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Previous bypass surgery <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Previous angioplasty/stent <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Varicose veins <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Valve Replacement <input type="checkbox"/> yes <input type="checkbox"/> no</p>
---	--

Surgeries- Please list all surgeries INCLUDING type of surgery and date of surgery

1.	5.
2.	6.
3.	7.
4.	8.

SOCIAL HISTORY AND LIFESTYLE Please check appropriate box as it applies to YOU

<p>Alcohol Use Do you consume alcohol? <input type="checkbox"/> yes <input type="checkbox"/> no Average # per day: <input type="text"/> beer <input type="text"/> wine <input type="text"/> liquor</p> <p>Smoking/Tobacco Use Do you smoke or use tobacco? <input type="checkbox"/> yes <input type="checkbox"/> no Have you smoked in the past? <input type="checkbox"/> yes <input type="checkbox"/> no Number of years? _____ Packs per day: _____</p> <p>Diet Are you on a special diet? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what type of diet? _____ Do you drink caffeinated beverages? (Including coffee, tea, cola, etc) <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how many daily? _____</p> <p>Exercise Do you exercise on a regular basis? <input type="checkbox"/> yes <input type="checkbox"/> no (Minimum of 30 minutes / 3 times a week)</p> <p>Substance Abuse Do you have a history of drug/alcohol dependency? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, specify: _____</p>	<p>Lifestyle <input type="checkbox"/> single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed</p> <p>Occupation <input type="checkbox"/> Employed: _____ <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed</p> <hr/> <p>Residence <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with children <input type="checkbox"/> Lives with parents <input type="checkbox"/> Lives with spouse <input type="checkbox"/> Lives with spouse and children <input type="checkbox"/> Lives with male partner <input type="checkbox"/> Lives with female partner <input type="checkbox"/> Nursing home resident <input type="checkbox"/> Assisted living resident</p>
--	--

FAMILY MEDICAL HISTORY

Father	<input type="checkbox"/> Alive and well <input type="checkbox"/> Deceased, if so at what age: _____ Cause of death: _____ <input type="checkbox"/> Did your father have any of the following <input type="checkbox"/> Did your father have a heart attack before age 60, if so, please check box. <input type="checkbox"/> Did your father have a stroke, if so, please check box.
Mother	<input type="checkbox"/> Alive and well <input type="checkbox"/> Deceased, if so at what age: _____ Cause of death: _____ <input type="checkbox"/> Did your mother have any of the following <input type="checkbox"/> Did your mother have a heart attack before age 60, if so, please check box. <input type="checkbox"/> Did your mother have a stroke, if so, please check box.
Sibling(s)	<p>_____ Number of Brother(s) # _____ Alive <input type="checkbox"/> Did your brother(s) have a heart attack before age 60 # _____ Deceased <input type="checkbox"/> Did your brother(s) have a stroke, if so at what age? _____ at what age did your brother(s) die _____ Cause of death: _____</p> <p>_____ Number of Sister(s) # _____ Alive <input type="checkbox"/> Did your sister(s) have a heart attack before age 60 # _____ Deceased <input type="checkbox"/> Did your sister(s) have a stroke, if so at what age _____ at what age did your sister(s) die _____ Cause of death: _____</p>

REVIEW OF SYSTEMS

Circle if YOU are experiencing symptoms or check "No Symptoms"

General <input type="checkbox"/> <i>No Symptoms</i> Decreased appetite Fever Recent weight loss/gain	Respiratory <input type="checkbox"/> <i>No Symptoms</i> Cough Coughing up blood Wheezing	Genitourinary <input type="checkbox"/> <i>No Symptoms</i> Blood in urine Pain with urination
Integumentary (Skin) <input type="checkbox"/> <i>No Symptoms</i> Rash	Cardiovascular <input type="checkbox"/> <i>No Symptoms</i> Chest pain, pressure or tightness Have you passed out Heart palpitations (racing) History of blood clots or phlebitis Irregular heart beats Non healing sores on legs or feet Pain in legs with walking Short of breath lying flat Swelling of feet or ankles Waking up panicky short of breath	Neurological <input type="checkbox"/> <i>No Symptoms</i> Headaches Numbness/tingling on one side Weakness on one side
Eyes <input type="checkbox"/> <i>No Symptoms</i> Blurred vision Double vision	Endocrine <input type="checkbox"/> <i>No Symptoms</i> Excessive thirst Increased urination	Hematological <input type="checkbox"/> <i>No Symptoms</i> Bleed easily Bruise easily
Ears, Nose, and Throat <input type="checkbox"/> <i>No Symptoms</i> Difficulty speaking Hearing loss Hoarseness Nose bleeds	Gastrointestinal System <input type="checkbox"/> <i>No Symptoms</i> Blood in stool Black stools Difficulty swallowing solid/liquids Heartburn	

Bring to your Appointment

♥ **Medications** in their original containers

♥ **Current insurance cards**

Even if we have copied them in the past