Deborah SPECIALTY PHYSICIANS

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Date____/_____/_____

Patient Name_____ **Date of Birth**_____ **Social Security #**_____-____-_____

Address _____ Home Phone_____ Cell Phone_____

Emergency Contact _____ Phone Number_____ Relation_____

Primary Care Physician name_____ City / State:_____

Physician's Office phone #_____ Physician's Office FAX #_____

Preferred Lab name & address _____

Preferred Radiology facility name & address _____

Pharmacy Name & FAX #_____

CHIEF COMPLAINT

What concerns are you here for today?

_____

PROBLEM LIST

Please check any of the following disorders that <u>you currently have, or have had</u>, and the year it was first identified.

CARDIAC:

☐Yes ☐No Cardiomegaly (enlarged heart)_____ ☐Yes ☐No Coronary Artery Disease _____

☐Yes ☐No Rheumatic Fever_____ ☐Yes ☐No Arrhythmia / Abnormal Rhythm _____

☐Yes ☐No Murmur _____ ☐Yes ☐No Previous Cardiac Arrest _____

☐Yes ☐No Abnormal Heart Valve _____ ☐Yes ☐No Defibrillated /"Shocked"_____

☐Yes ☐No Endocarditis (infected heart lining/valve)_____ ☐Yes ☐No Pericardial Disease (sac surrounding heart) _____

☐Yes ☐No Abnormal ECG_____ ☐Yes ☐No Marfan syndrome _____

☐Yes ☐No Angina (heart pain) _____ ☐Yes ☐No Hospitalized for cardiac reasons_____

☐Yes ☐No Heart Attack _____ ☐Yes ☐No Other type of heart disease_____

☐Yes ☐No Heart Disease (born with/congenital) _____ ☐Yes ☐No Heart Failure / Cardiomyopathy _____

VASCULAR:

☐Yes ☐No Carotid Artery Disease _____ ☐Yes ☐No Stroke or TIA (mini-stroke) _____

☐Yes ☐No Renal (Kidney) Artery Disease_____ ☐Yes ☐No Any history of aneurysm _____

☐Yes ☐No Peripheral (leg or arm) Artery Disease_____ ☐Yes ☐No DVT (clots in leg) _____

☐Yes ☐No Pulmonary embolism (clots in lung) _____ ☐Yes ☐No Other type of Vascular Disease_____

☐Yes ☐No Varicose Veins _____

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CORONARY RISK FACTORS

☐Yes ☐No Hypertension (high blood pressure) _____ ☐Yes ☐No Diabetes Mellitus _____

☐Yes ☐No Abnormal Cholesterol / Triglycerides _____ ☐Yes ☐No Currently Smoking? _____

Please list all medications, non-prescriptions, vitamins and supplements, attaching additional pages if necessary.

	Name of Medication/Supplement	**Dose/Strength**	**How many/How often/When**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

ALLERGIES / INTOLERANCES TO MEDICATIONS

	Medication	Reaction
1.		
2.		
3.		
4.		
5.		

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Medication	Reaction
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Patient Medical History

Please check any of the following disorders that **you currently have, or have had**, and indicate the year it was first identified.

PULMONARY:

☐Yes ☐No Asthma_____ ☐Yes ☐No Bronchitis _____

☐Yes ☐No Emphysema / COPD_____ ☐Yes ☐No Tuberculosis_____

☐Yes ☐No Pneumonia_____ ☐Yes ☐No Sleep Apnea_____

GASTROINTESTINAL:

☐Yes ☐No Reflux (GERD)_____ ☐Yes ☐No Hiatal Hernia_____

☐Yes ☐No Diverticulosis /Diverticulitis_____ ☐Yes ☐No Ulcers_____

☐Yes ☐No Liver Disease /Hepatitis_____ ☐Yes ☐No Gastritis_____

☐Yes ☐No Gallbladder Disease /Gallstones_____ ☐Yes ☐No Gastrointestinal Bleed_____

RENAL / GENITOURINARY:

☐Yes ☐No Dialysis_____ ☐Yes ☐No Prostate Disease_____

☐Yes ☐No Kidney _____ ☐Yes ☐No Kidney Disease /Elevated Creatinine_____

NEUROLOGICAL / PSYCHOLOGICAL:

☐Yes ☐No Intracranial (in the brain) Bleeding_____ ☐Yes ☐No Seizure Disorder _____

☐Yes ☐No Migraine Headaches _____ ☐Yes ☐No Dementia_____

☐Yes ☐No Depression _____ ☐Yes ☐No Anxiety Disorder_____

Female Reproductive:

☐Yes ☐No Miscarriages_____ ☐Yes ☐No Currently Pregnant (number of weeks)_____

☐Yes ☐No Menopause (at what age?)_____

ENDOCRINE:

☐Yes ☐No Thyroid Disorder _____ ☐Yes ☐No Adrenal Disorder_____

OTHER:

☐Yes ☐No Anemia _____ ☐Yes ☐ No Bleeding Disorder_____

☐Yes ☐No Clotting Disorder_____ ☐Yes ☐No Gout_____

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☐Yes ☐No Arthritis _____ ☐Yes ☐No Ambulate with assistance_____

☐Yes ☐No HIV_____ ☐Yes ☐No Reaction to iodine contrast _____

☐Yes ☐No Previous exposure to iodine contrast_____ ☐Yes ☐No Vertigo _____

☐Yes ☐No Cancer (type)_____

☐Yes ☐No Autoimmune Disorders (i.e., Lupus, Hashimotos) _____

☐Yes ☐No Previous Weight Loss Meds (i.e., Fen Phen) _____

Please list any other health problems that are not on the list:

_____

SURGICAL HISTORY / OPERATIONS

Please list any surgeries you have had:

Surgery	Date	Surgeon	Location

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Number of children_____ With whom do you live? _____

Do you have a Medical Power of Attorney? ☐Yes ☐No Who?_____ Relationship: _____

Advanced Directive ☐Yes ☐No ☐ Do Not Resuscitate

Healthcare Proxy ☐Yes ☐No Who?_____ Relationship: _____

Living Will ☐Yes ☐No Date:_____

Currently Employed or Retired?_____ If employed, your current occupation_____

Your past occupation(s)_____

Primary language_____ Secondary language_____

Leisure activities (include any hobbies) _____

Home exercise equipment? ☐Yes ☐No If yes, what types:_____

Home blood pressure monitor? ☐Yes ☐No If yes, Average Readings:_____

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Do you use tobacco? ☐ **Yes** ☐ **Formerly** ☐ **Never**

☐ Cigarettes _____per day # of Years Smoked _____ Quit Date _____

☐ Cigars_____per day # of Years Smoked _____ Quit Date _____

☐ Pipes_____per day # of Years Smoked _____ Quit Date_____

☐ Chewing tobacco _____per day # of Years Smoked _____ Quit Date _____

Do you use alcohol? ☐ **Yes** ☐ **Formerly** ☐ **Never**

Describe your use:

☐ **Rarely** ☐ **Social** ☐ **Daily** ☐ **Frequently** ☐ **Occasional** ☐ **Quit Date _____**

Type:	How much?
☐ Beer	_____cans per day /_____ per week / _____ per month
☐ Wine	_____glasses per day / _____ per week / _____ per month
☐ Spirits	_____glasses per day / _____ per week / _____ per month

Do you use caffeine? ☐ **Yes** ☐ **Formerly** ☐ **Never**

Type:

☐ Caffeinated Coffee? _____ cups per day / _____ per week

☐ Caffeinated Tea? _____ cups per day / _____ per week

☐ Caffeinated Soda? _____ cups per day / _____ per week

Do you use recreational drugs? ☐ **Yes** ☐ **Formerly** ☐ **Never**

Type:	Amount:	Start / Quit Dates:
☐ Marijuana	_____ per day	Years Smoked _____ Quit Date _____
☐ Cocaine	_____ per day	Years Smoked _____ Quit Date _____
☐ Methamphetamine	_____ per day	Years Used _____ Quit Date _____
☐ Other	_____ per day	Years Used _____ Quit Date _____

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Exercise?

☐ No/Sedentary ☐ Occasional ☐ Regular ☐ Active Lifestyle ☐ Physically unable to exercise

Type:	How much:	
☐ Aerobics	How long? (Mins.)_____	How often per week?_____
☐ Cycling	How long? (Mins.)_____	How often per week?_____
☐ Dancing	How long? (Mins.)_____	How often per week?_____
☐ Jogging	How long? (Mins.)_____	How often per week?_____
☐ Running	How long? (Mins.)_____	How often per week?_____
☐ Swimming	How long? (Mins.)_____	How often per week?_____
☐ Team sport	How long? (Mins.)_____	How often per week?_____
☐ Walking	How long? (Mins.)_____	How often per week?_____
☐ Weights	How long? (Mins.)_____	How often per week?_____

Please choose the type of diet you are currently on:

Type:	How well do you follow it?			
☐ Regular				
☐ Low fat/Chol	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet
☐ Low salt	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet
☐ Diabetic	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet
☐ Renal	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet
☐ No Added Salt	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet
☐ Weight Loss	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet
☐ Low Carb	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet
☐ Vegetarian	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non-compliant with diet

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FAMILY HISTORY

Please indicate below if your FATHER, MOTHER, SIBLING(S), or CHILDREN have ever been diagnosed with any of the following conditions, by writing the age (not a check mark) at which the condition first occurred in the appropriate box.

Note: If there is no history of these conditions or if they are unknown, then check the None or Unknown box in the appropriate column.

Condition	Father	Mother	Sister(s)	Brother(s)	Children
Angina					
Heart Attack					
Angioplasty					
Heart Surgery					
Abnormal Heart Rhythm					
Sudden/Unexpected Death					
Stroke/TIA (mini-stroke)					
Blood Clots					
Heart Failure/Cardiomyopathy					
Aneurysm					
None of the above					
Unknown					
Current age					
Deceased age					

Other family members (aunts, uncles, cousins, grandparents) with heart problems:

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Patient Name_____ **Date of Birth**_____

Please check the "Yes" or "No" box to indicate if you are experiencing or have experienced any of the following signs or symptoms in the last three months.

REVIEW OF SYSTEMS

CONSTITUTIONAL:	Yes	No
Significant weight loss	☐	☐
Significant weight gain	☐	☐

ENMT:	Yes	No
Excessive Snoring	☐	☐

RESPIRATORY	Yes	No
Coughing up blood	☐	☐

GASTROINTESTINAL:	YES	No
Blood in stool (black stool)	☐	☐

GENITOURINARY:	Yes	No
Blood in urine	☐	☐

VASCULAR:	Yes	No
Calf pain with walking	☐	☐

MUSCULOSKELETAL:	Yes	No
Muscle pain at rest	☐	☐

NEUROLOGICAL:	Yes	No
Dizziness	☐	☐

PSYCHIATRIC:	Yes	No
Excessive stress	☐	☐

ENDOCRINE:	Yes	No
Feel cooler	☐	☐

HEMATOLOGICAL:	Yes	No
Unusual bleeding	☐	☐

CARDIAC:	Yes	No
Chest Pains	☐	☐
Chest Pressure	☐	☐

	Yes	No
Shortness of breath	☐	☐
Difficulty breathing while lying flat	☐	☐
Awakening with breathing difficulty	☐	☐

	Yes	No
Swelling in feet/ankles	☐	☐

	Yes	No
Palpitations	☐	☐

	Yes	No
Nearly passing out spells	☐	☐
Passing out spells	☐	☐

Any other reason why you need to see a cardiologist?

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire!

Patient Signature_____

Date: _____ Reviewed By:_____