

Patient Name _____ MR# _____ Date _____

Birthday _____ Age _____ Primary Care MD or Referring MD _____

Pharmacy/Address/City/State/Zip _____ Phone # _____

Reason for today's visit _____ Recent Testing (radiology, procedure, lab work?) Yes No

What? _____ Where? _____

Any new medical problems, hospitalizations or surgeries since your last visit? _____

Medical History:

Are you currently experiencing any of the following symptoms? (check Yes or No)

- | Yes | No | Yes | No | Yes | No | Yes | No |
|-------------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|----------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| chest pain | | chills | | blood in urine | | excessive snoring | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| shortness of breath | | fever | | blood in stool | | cold or heat intolerance | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fatigue | | weight gain | | abdominal pain | | excessive thirst/urination | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| muscle weakness/pain | | weight loss | | indigestion | | vision changes | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| exercise intolerance | | swelling | | nausea | | ringing in ears | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dizziness | | easy bruising | | vomiting | | vertigo | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| passing out | | nose bleeds | | cough | | seizures | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| palpitations | | vomiting blood | | wheezing | | male impotence | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| pain in legs/buttocks at rest | | pain in legs/buttocks when walking | | | | | |

Are you allergic to any medications? No Yes (list) _____

Are you allergic to IV Dye/Contrast? Yes No **Shellfish?** Yes No

Have you been treated for any of the following conditions? (check Yes or No)

- | Yes | No | Yes | No | Yes | No | Yes | No |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| high blood pressure | | high cholesterol | | kidney problems | | tuberculosis (TB) | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| heart failure | | blood clots | | rheumatic fever | | cancer | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| blockage of the heart | | stroke | | hiatal hernia | | sleep apnea | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | |
| blockage of the neck/leg | | diabetes | | stomach problems | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| abnormal heart rhythm | | lung disease | | thyroid problems | | | |

Social History:

Marital Status: Married Single Widowed Divorced **Do you have an Advanced Plan of Care/Directive?** Yes No

Work Status: Employed Unemployed Retired Disabled **Occupation:** _____

Exercise? No Yes **What do you do and how often?** _____

Caffeine? No Yes **What and how much?** _____

Smoke? No Yes **How many packs per day?** _____ **How long?** _____ **Interested in Quitting?** No Yes

Alcohol? No Yes **What and how much?** _____

Recreational Drugs? No Yes **What and how much?** _____

Preventive Care History:

Have you received the annual flu vaccination? Yes No **Pneumonia vaccination within the last 5 yrs?** Yes No

Are you currently taking an Aspirin or other antiplatelet daily? Yes No **If other, what?** _____

Are you currently taking Warfarin or other anticoagulant? Yes No **If other, what?** _____

Family History:

Are there members of your immediate family with the following conditions or history?

Heart Disease? Yes No Who? _____ Age of 1st episode _____

Heart surgery? Yes No Who? _____ Age of 1st episode _____

Irregular heart rhythms? Yes No Who? _____ Age of 1st episode _____