Patient Name: _____ Date of Birth:_____ Date: _____

Past Medical History

Please check and add details out to the side

Have you ever been told that you had:

- ☐ Anemia
- ☐ Asthma
- ☐ Aneurysm: abdominal ☐ thoracic
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ Coronary artery disease
- ☐ Cancer
- ☐ Cellulitis
- ☐ Claudication
- ☐ Congestive heart failure
- ☐ Connective Tissue Disease (Lupus,Sardcoidosis,etc)
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ CVA/Stroke
- ☐ Deep Vein Thrombosis
- ☐ Diabetes (insulin or non-insulin dependent)
- ☐ Dialysis
- ☐ Endocarditis
- ☐ Gastrointestinal Bleed
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Heart block
- ☐ Hypertension
- ☐ Irregular heart rhythm
- ☐ Liver disease
- ☐ Lipid disorder
- ☐ MI (heart attack)
- ☐ Murmur
- ☐ MVP (mitral valve prolapse)
- ☐ PAH (Pulmonary Artery Hypertension)
- ☐ Phlebitis
- ☐ Pleurisy
- ☐ PUD (peptic ulcer disease)
- ☐ Pulmonary Embolism
- ☐ PVD (peripheral vascular disease)
- ☐ Renal Failure ☐ Insufficency
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Seizure Disorder
- ☐ SVT (supraventricular tachycardia)
- ☐ Syncope
- ☐ TB (tuberculosis)
- ☐ Thyroid disorder
- ☐ TIA (transient ischemic attack)
- ☐ Valvular Heart Disease
- ☐ Ventricular Tachycardia

Surgical History

Please check and list date / facility / surgeon

- ☐ Abdominal Surgery _____
- ☐ Amputation: above knee
- ☐ Amputation: below knee
- ☐ Anesthesia Problems
- ☐ Aneurysm Repair
- ☐ Aortic Valve Repair ☐ Replacement
- ☐ Appendectomy
- ☐ Arteriogram ☐ carotid ☐ legs ☐ kidneys
- ☐ Bypass: Aorta-femoral ☐ left ☐ right
- ☐ Bypass: Fem-pop ☐ left ☐ right
- ☐ CABG (Open heart)
- ☐ Congenital heart surgery
- ☐ Endarterectomy ☐ Lt carotid ☐ Rt carotid
- ☐ EPS (Electrophysiology Study)
- ☐ Gallbladder surgery
- ☐ Heart Cath (dye test)
- ☐ ICD (Defibrillator) ☐ ICD : Bi-V
- ☐ Mitral Valve Repair ☐ Replacement
- ☐ Pacemaker
- ☐ PTCA (Angioplasty / stent) heart
- ☐ PTCA (Angioplasty / stent) leg ☐ kidney
- ☐ Stent ☐ Aorta ☐ Carotid ☐ Iliac
- ☐ Surgical Complications
- ☐ Thyroid surgery
- ☐ Venous Ablation
- ☐ Vein Stripping

Other operations _____

_____

_____

_____

Patient Name: _____ Date: _____

Home Medications

List all medications & dosage you are presently taking and how frequently you take them:

Medication / Dose / Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all known allergies:

_____
_____
_____

Do you have a living will or an advanced directive?

- ☐ Yes
- ☐ No
- ☐ Do not care to discuss

Family History

Please check and add any details out to the side	*Please circle family member(s) where applicable*
☐ Unknown	[father, mother, sibling, grandparent]
☐ Aortic Aneurysm	[father, mother, sibling, grandparent]
☐ Asthma	[father, mother, sibling, grandparent]
☐ Bleeding Disorder	[father, mother, sibling, grandparent]
☐ Cancer _____	[father, mother, sibling, grandparent]
☐ Congestive Heart Failure	[father, mother, sibling, grandparent]
☐ Connective Tissue Disease	[father, mother, sibling, grandparent]
☐ Coronary Artery Disease	[father, mother, sibling, grandparent]
☐ Coronary Heart Disease-male < 55	[father, sibling, grandparent]
☐ Coronary Heart Disease-female < 55	[mother, sibling, grandparent]
☐ CVA or Stroke	[father, mother, sibling, grandparent]
☐ Diabetes	[father, mother, sibling, grandparent]
☐ Hyperlipidemia (cholesterol problems)	[father, mother, sibling, grandparent]
☐ Hypertension	[father, mother, sibling, grandparent]
☐ Marfan's Syndrome	[father, mother, sibling, grandparent]
☐ PAH (Pulmonary Artery Hypertension)	[father, mother, sibling, grandparent]
☐ Peripheral vascular disease	[father, mother, sibling, grandparent]
☐ Prolonged QT	[father, mother, sibling, grandparent]
☐ Renal Disease	[father, mother, sibling, grandparent]
☐ Sudden Cardiac Death	[father, mother, sibling, grandparent]
☐ Thyroid Disease	[father, mother, sibling, grandparent]

Mother living? Yes No Age at death _____ Father living? Yes No
Age at death _____ Number of living brothers & sisters _____ Number of deceased brothers & sisters _____

Social History

Marital Status: Single, Married, Divorced, Widowed

How many children do you have? _____

What is your occupation: _____

Disabled Retired

Smoking History:

Current Smoker: year started _____

Cigarettes: _____ packs per day

Cigars: _____ number per week

Smokeless: _____ amount per day

Counseled to quit or cut down: Yes No

Former smoker: year quit _____

Never smoked:

Passive smoke exposure Yes No

Do you drink alcoholic beverages? Yes No

Types of Alcohol? _____

How many drinks per day? _____

Drug Use? Yes No (If yes circle type below)

Marijuana, cocaine, crack, heroin, illicit prescription
Other _____

Do you drink caffeinated drinks? Yes No

How many per day? _____

Do you drink diet drinks? Yes No

Are you on a special diet? Yes No

Calorie Limited Low Salt
Low Fat Diabetic
High Fiber Low Cholesterol
Other _____

Do you exercise on a regular basis? Yes No
How many times per week? _____
Type of exercise? _____

Do you have a barrier to communication? Yes No
(If yes, circle impairment below)

Non-English Speaking Hearing Impairment
Vision Impairment

High Risk Behavior? Yes No

Comments: _____

Cardiology Consultants

Patient Name: _____ Date of Birth: _____ Date: _____

Review of Systems (please check if you have any of the following)

General

- ☐ Daytime sleepiness
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Cardiovascular

- ☐ Chest pain
- ☐ Fainting
- ☐ Heart racing (palpitations)
- ☐ Swelling in feet/legs (peripheral)

Respiratory

- ☐ Cough
- ☐ Excessive snoring
- ☐ Shortness of breath
- ☐ Wheezing

Neurologic

- ☐ Dizziness (lightheadedness)
- ☐ Morning headaches

Gastro-Intestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Indigestion
- ☐ Dark tarry stools
- ☐ Nausea
- ☐ Vomiting

Genital-Urinary

- ☐ Difficult urination (dysuria)
- ☐ Blood in urine (hematuria)

Musculo-Skeletal

- ☐ Leg pain
- ☐ Muscle cramps

Dermatologic

- ☐ Non-healing ulcer
- ☐ Scar to chest
- ☐ Scar to leg

Ears, Nose, Throat

- ☐ Hoarseness
- ☐ Nosebleed

Psychiatric

- ☐ Anxiety
- ☐ Depression

Allergies

- ☐ Allergic to dye
- ☐ Allergic to iodine
- ☐ Allergic to medications
- ☐ Allergic to shellfish

Form Completed By

Physician Signature