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Patient's Name: ________________________________ DOB:___________ Date: __________

Email: __________________________________________________________

What is the reason for your visit? _________________________________________________

Who is your primary care doctor? _________________________________________________

Please circle all that apply
Do you have chest pain (sharp, dull, burnung) / pressure / tightness / heaviness? ...... Yes / No
How severe? Minimal/mild/mild to moderate/moderate/moderate to severe/severe
About when did it start? _____ days / weeks / months / years ago
How how often do you get CP? ____ times in a days / weeks / months / years / constant
How long does the CP last? ____ seconds / minutes / hours / varies / constant
Where is the pain? Chest / epigastric / left arm / right arm / shoulder / back / jaw / neck
Where does the pain radiate? Left arm / right arm / shoulder / back / jaw / neck / no where
Aggravated by exertion / stress / inspiration / lying down / sitting up / movement / None
Relieved by rest / nitro / change in position / food / antacid / none
Is the pain associated with nausea, vomiting, sweating? .......................................... Yes / No
Does it hurt when you press on your chest wall? ...................................................... Yes / No
Have you had any recent injuries to your chest wall? ............................................... Yes / No
Have you had heart surgery? .......................................... Yes / No If yes when? ___________
Have you had an angiogram, CATH or dye test on your heart? .................................... Yes / No
Does it hurt in your legs, thigh or buttocks when you walk? ...................................... Yes / No

Shortness of breath:
Do you get short of breath? Yes / No
How severe? Minimal/mild/mild to moderate/moderate/moderate to severe/severe
About when did it start? _____ days / weeks / months / years ago
How how often do you get SOB? ____ times in a days / weeks / months / years / constant
How long does the SOB last? ____ seconds / minutes / hours / varies / constant
What does it feel like? Pressure / tightness / hard to get air in / air out / squeezing sensation
Aggravated by daily activities / exertion / stress / mild activities / stairs / none
Relieved by rest / fresh air / nebulizer / sitting / none

Edema (Swelling):
Do you have any swelling? Yes / No
How severe? Minimal/mild/mild to moderate/moderate/moderate to severe/severe
Symptoms: aching / coldness / cramping / pain / redness / swelling / none
Location: Right / Left / ankle / buttock / calf / thigh / foot
Aggravated by: Exercise / rest / smoking / climbing hill / none
Releived by? Elevation / warm compress / cold compress / massage / walking / none
Additional symptoms? back pain / chest pain / difficulty swallowing / dizziness / headache

Palpitations:
Do you feel you heart skip beats / irregular heart beats / rapid beats / none
How severe? Minimal/mild/mild to moderate/moderate/moderate to severe/severe
About when did it start? _____ days / weeks / months / years ago
How how often? ____ times in a days / weeks / months / years / constant
How long does it last? ____ seconds / minutes / hours / varies / constant
Aggravated by: exercise / anxiety / stress / caffeine / alcohol / medications / none
Relieved by: cough / cold water to face / rest / medications / none

Syncope:
Do you feel like you are going to pass out or have you passed out? Yes / No
Quality: floating/imbalance/light-headedness/spinning/unstable horizon/loss of consiousness
Context: sitting to standing / no warning /vertigo / venipunture / other _________________
Aggravated by: alcohol/dehydration/change in position/exercise/heat/head turning/none
Relieved by: medication / lying down / rest / sitting / none

When was your last blood test? __________________ Where? _________________________
When was the last time your cholesterol was tested? ___________ Where?______________

Have you been in the hospital recently? Yes / No If yes, which hospital? ________________

Have you been seen by a cardiologist in the past? Yes / No If yes, Name?________________

Name of the preferred local pharmacy? _________________________ Phone: _______________
Name of preferred mail in pharmacy? _________________________ Phone: _________________

Your height: __________ Weight: ___________

Exercise capacity:
Can you walk two blocks rapidly without much chest pain or shortness of breath? ..... Yes / No

Past medical history: (Circle all that apply)
Heart disease / heart attack / chest pain / weak heart / congestive heart failure / diabetes / hypertension / high cholesterol / stroke / blockage in your legs / stomach ulcer disease / other:
________________________________________________________________________________

Past surgical history:
Heart surgery / pacemaker / defibrillator / hysterectomy / appendectomy / other: __________
________________________________________________________________________________

Family history: Unknown / Adopted
Mother: Age___ Living / Deceased Health problems: __________________________________
Father: Age___ Living / Deceased Health problems: __________________________________
Brothers: Age___ Living / Deceased Health problems: ________________________________
Age___ Living / Deceased Health problems: __________________________________
Age___ Living / Deceased Health problems: _________________________________
Sisters: Age___ Living / Deceased Health problems: __________________________________
Age___ Living / Deceased Health problems: __________________________________
Age___ Living / Deceased Health problems: __________________________________
Children: Age___ Living / Deceased Health problems: _________________________________
Age___ Living / Deceased Health problems: _________________________________
Age___ Living / Deceased Health problems: _________________________________

Social History:
Who do you live with at home? ______________________________________________________
# of children _____ Boys _____ Girls
What kind of work do you do/did? ___________________________________________________
Do you smoke, or have you ever smoked? Yes / No If yes how much?_____ cigs/packs per day.
How old were you when you started? ______ When you quit?______
Do you drink alcohol? Yes / No What do you drink? _______________ How much? _________
Do you drink caffeine? Yes / No What do you drink? _______________ How much? ________
Do you follow any type of diet? Yes/ No Low salt / low cholesterol / diabetic / weight loss
Do you exrecise? Yes / No How often? ________ What do you do?______________________

Medications: Please list all medications you are taking. (If you have your medications with you skip this section)

_______________________________________ _____________________________________
_______________________________________ _____________________________________
_______________________________________ _____________________________________
_______________________________________ _____________________________________
_______________________________________ _____________________________________

Do you use any street drugs? .............Yes/ No
Do you carry Nitro? ...........................Yes/ No
Have you taken any diet meds? .........Yes/ No
Do you take aspirin every day? .....Yes/ No
Do you take cholesterol meds? .....Yes/ No

Are you allergic to any medications? No / Dye / Contrast / Fish Oil / Iodine / Penicillin / Codeine / Morphine / Apirin / Other: _________________________________________________

Review of systems:

Do you have any of the following?

Cardiac:

Chest pain? ....................................Yes/ No
Abnormal sweating? ....................Yes/ No
Palpitations? ..................................Yes/ No
Have you passed out? ...................Yes/ No

Vascular:

Pain in your legs when you walk?.....Yes/ No
Swelling in your legs? ..................Yes/ No

Constitutional:

Weight gain? ..................................Yes/ No
Weight loss? ...............................Yes/ No

HEENT:

Changes in your vision? ..................Yes/ No
Trouble hearing? .........................Yes/ No

Respiratory?

Do you snore? ................................Yes/ No
Cough up blood? .........................Yes/ No
Shortness of breath? .......................Yes/ No
Fever? .......................................Yes/ No

Gastrointestinal:

Nausea? ........................................Yes/ No
Acid reflux? ...............................Yes/ No
Blood in your stools? .......................Yes/ No

Genitourinary:

Blood in your urine? ........................Yes/ No
Use the restroom frequently at night? Yes/ No

Neurological?

Dizziness? ......................................Yes/ No
Memory loss? ............................Yes/ No
Seizures? .......................................Yes/ No

Pyschiatric:

Are you depressed? ........................Yes/ No
Hallucinations? ..........................Yes/ No

Hematologic:

Are you anemic? ............................Yes/ No
Abnormal blood count? .............Yes/ No

Endocrine:

Thyroid problems? ..........................Yes/ No
Tremors? ...................................Yes/ No

Derm:

Skin rash? .......................................Yes/ No
Skin sores? ................................Yes/ No

Musculoskeletal:

Joint Pain? ......................................Yes/ No
Muscle pain? ............................Yes/ No

**<u>Over the past 2 weeks, how often have you been bothered by any of the following problems?</u>**

Little interest or pleasure in doing things?
Not at all / several days / more than half / every day

Feeling down, depressed or helpless?
Not at all / several days / more than half / every day

Trouble falling or staying asleep or sleeping to much?
Not at all / several days / more than half / every day

Feeling tired or having little energy?
Not at all / several days / more than half / every day

Poor appetite or overeating?
Not at all / several days / more than half / every day

Feeling bad about yourself, that you are a failure or have let yourself or your family down?
Not at all / several days / more than half / every day

Trouble concentrating on things such as reading the newspaper or watching television?
Not at all / several days / more than half / every day

Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been mobing around a lot more that usual?
Not at all / several days / more than half / every day

Thoughts that you would be better off dead, or hurting yourself in some way?
Not at all / several days / more than half / every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take are of things at home or get along with other people?
Not difficult at all / somewhat difficult / very difficult / extremely difficult