



Cardiology

PATIENT INFORMATION

Name: _____ Date of Birth: ____ / ____ / ____
Last First Middle

Date of Last Physical Exam: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

What is the reason for your visit? _____

Have you been seen by a Cardiologist before? Yes/No Physician Name: _____ Phone: _____

HISTORY:

Hospitalization/Procedures

Year	Hospital	Procedure	Reason for Hospitalization and Outcome

Illness/Injuries

Serious Illness/Injuries	Date	Outcome

Medications

Medication	Dose	How many times a day?

Social History: (Please check one) Yes No

- 1. Do you use tobacco? Yes No Packs or amount per week: _____
- 2. Do you use alcohol? Yes No Consumption per week: _____
- 3. Do you use recreational drugs? Yes No Type: _____
- 4. Do you have children? Yes No How many: _____
- 5. Do you exercise? Yes No ___ Daily ___ Weekly ___ Rarely
- 6. Do you drink caffiene? Yes No Consumption per week: _____

Allergies: _____

Have you ever had problems with general anesthesia? ___ Yes ___ No

Do you have a latex allergy? ___ Yes ___ No



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SYMPTOMS Check mark symptoms you currently have or have had in the past year.

General

- Chills, Depression, Dizziness, Fainting, Fever, Forgetfulness, Headache, Loss of sleep, Loss of weight, Nervousness, Numbness, Sweats

Muscle/Joint/Bone

Pain weakness, numbness in

- Arms, Back, Feet, Hands, Hips, Legs, Neck, Shoulders

Genito Urinary

- Blood in urine, Frequent urination, Lack of bladder control, Painful urination

Gastrointestinal

- Appetite Poor, Bloating, Bowel changes, Constipation, Diarrhea, Excessive hunger, Excessive thirst, Gas, Hemorrhoids, Indigestion, Nausea, Rectal bleeding, Stomach pain, Vomiting, Vomiting blood

Cardiovascular

- Chest pain, High blood pressure, Irregular heart beat, Low blood pressure, Poor circulation, Rapid heart beat, Swelling of ankles, Varicose veins

Eye, Ear, Nose, Throat

- Bleeding gums, Blurred vision, Crossed eyes, Difficulty swallowing, Double vision, Earache, Ear discharge, Hay fever, Hoarseness, Loss of hearing, Nose bleeds, Persistent cough, Ringing in ears, Sinus problems, Vision - flashes, Vision - halos

Respiratory

- Shortness of breath, Asthma, Cough, Emphysema

Skin

- Bruise easily, Hives, Rash, Itching, Scars, Change in moisture, Sore that won't heal

MEN ONLY

- Breast lump, Erection difficulty, Lump in testicles, Penis discharge, Sore on penis, Other: _____

WOMEN ONLY

- Abnormal Pap Smear, Bleeding between periods, Breast Lump, Extreme menstrual pain, Hot flashes, Nipple discharge, Painful discharge, Painful intercourse, Other: _____, Date of last menstrual period: _____, Date of last pap smear: _____, Have you had a mammogram? Yes/No, Are you pregnant? Yes/No

CONDITIONS Check mark conditions you currently have or have had in the past year.

- AIDS, Alcoholism, Anemia, Appendicitis, Arthritis, Bleeding Disorders, Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken pox, Diabetes, Emphysema, Epilepsy, Glaucoma, goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pacemaker, Pneumonia, Polio, Prostate Problem, Psychiatric Care, Rheumatic Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid fever, Ulcers, Vaginal Infections, Venereal Disease

Patient Signature: _____ Date: _____

Signature for patients under 18: _____ Relationship to patient: _____