**Name:** _____ **DOB:**_____ **Date:** _____

Please List Medications you are currently taking:

| MEDICATION NAME | | STRENGTH | HOW OFTEN PER DAY DO YOU TAKE THEM? | WHY ARE YOU TAKING THIS MEDICATION? |
|---|---|---|---|---|
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| Medication Allergies | | Allergic Reaction to Medication |
|---|---|---|
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Pharmacy You Use: _____ Address or Phone #:_____

**Do you have any of the following Risk Factors for Heart Disease?**

*(Please check Yes or NO, but if multiple answers given, please circle the appropriate one.)*

| | YES | NO |
|---|---|---|
| 1. Have you ever smoked? | | |
| If "YES"- Are you - (still smoking or have you quit?) How many packs /day ___ How many yrs _____ | | |
| 2. Any Family History of Heart Disease for: | | |
| For males before the age of 55? | | |
| For females before the age of 60? | | |
| 3. Have you had high cholesterol or Triglycerides in the past? | | |
| If Yes, are you currently controlled with medications? | | |
| 4. Have you been told you have high blood pressure? | | |
| If "YES"- Are you - (currently on medications? - Or are you controlling it with lifestyle?) | | |
| 5. Have you been diagnosed with Diabetes? | | |
| If "YES"- Are you on - (Insulin or oral medication?) (Or are you controlling it with lifestyle?) | | |
| 6. Do you have any prior history of heart disease? | | |
| 7. Are you active or do you live a sedentary lifestyle? | Active | Sedentary |
| 7. Are you overweight? | | |
| 8. Are you post menopausal? | | |
| If Yes, circle the appropriate type: Perimenopausal / Biological Menopause / Surgical Menopausal | | |
| If Yes, are you taking Hormone Replacement Medication? | | |
| 9. Are you over 60 years old? | | |

**Past Medical History:**

*What past Cardiac illnesses have you had?* When:

Have you ever had any of the following Conditions?

- ☐ Aortic Aneurysm of the Abdomen
- ☐ Asthma
- ☐ Anemia
- ☐ Arthritis (Osteoarthritis)
- ☐ Arthritis (Rheumatoid)
- ☐ Prostate Enlargement (BPH)
- ☐ Neck artery blockage (Carotid)
  (Right, Left, or Both)
- ☐ Colitis
- ☐ Ulcerative Colitis (Crohn's Disease)
- ☐ Emphysema (COPD)
- ☐ Stroke (CVA) with permanent Paralysis
- ☐ Stroke (CVA) with Paralysis
- ☐ **Cancer:** (cirlce all that apply)
  Breast Colon
  Liver Leukemia
  Lung Lymph glands
  Pancreas Prostate
  Skin Uterus
- ☐ Legs cramp when walking < 2 blks
- ☐ Hips cramp when walking < 2 blks.
- ☐ **Diabetes**: (Cirlce all that apply)
  On meds On Insulin
  Diet controlled only
- ☐ Stomach Ulcers: (Circle all that apply)
  Duodenal Gastric Peptic
- ☐ Bleeding from stomach ulcers
- ☐ Hiatal Hernia
- ☐ Gout
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Thyroid Gland Problems
  Low thyroid Too much thyroid
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Heart Valve Problems
  Aortic Mitral Tricuspid Pulmonary
- ☐ Atrial Fibrillation
- ☐ Heart Failure
- ☐ Ventricular Tachycardia
- ☐ Heart Attack:
  How Many? _____
  Dates: _____
- ☐ Diptheria
- ☐ Hepatitis
- ☐ Meningitis
- ☐ Childhood Disease: (Circle all that apply)
  Measles Mumps Chicken Pox
- ☐ Tuberculosis
- ☐ Pancreatitis
- ☐ Histoplasmosis

*What past Cardiac Tests have you had and when?* *When:*

Echocardiogram: _____

Stress echocardiogram: _____

Transesophageal Echo (TEE): _____

Nuclear Stress test: _____

CT Angiogram _____

Angiogram: _____

Regular Stress test: _____

MRI/MRA: _____

Other: Define _____

*What surgeries have you had?* *When:*

_____

_____

_____

_____

_____

_____

_____

**Please answer the following:**

*(Please check Yes or NO, but if multiple answers given, please circle the appropriate one.)*

| | YES | NO |
|---|---|---|
| Do you drink Alcohol? | | |
| If "YES"- ( Rarely - daily - weekly - holidays only?) # of drinks usually consumes: _____ | | |
| Type of alcohol drank: Beer - Wine - Mixed drinks | | |
| Are you on any special kind of diet? | | |
| Type of diet: | | |
| Amount of Caffeine drank per day: | | |

**Please answer the following:** (continued)

*(Please check Yes or NO, but if multiple answers given, please circle the appropriate one.)*

| | YES | NO |
|---|---|---|
| Do you exercise regularly? | | |
| If "YES" - How much and how often? | | |
| Lifestyle: Are you - ( Married - Single - Divorced - Widow ?) | | |
| Your Occupation? | | |
| Are you currently Retired? | | |
| Residence: Do you currently live alone or with family? | | |
| Place of Birth: | | |

**Family History:**

| *Family Member:* | *If Alive- current age and health issues:* | *If deceased -Cause and age at death* |
|---|---|---|
| Father | | |
| Mother | | |
| Brother | | |
| Sister | | |
| Additional Family: | | |
| | | |
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**Any additional Information you need to add:**

**Review of Systems:**

*(Please check the boxes that apply to you:*

- ☐ Recent Weight Loss
- ☐ Recent Weight Gain
- ☐ Fever/Chills
- ☐ Decrease exercise tolerance

- ☐ Any new moles or changes in your skin
- ☐ Changes in Hair or you finger nails

- ☐ Wear Glasses/Contacts
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Partial loss of vision
- ☐ Cataracts
- ☐ Macular Degeneration

- ☐ Hearing Loss
- ☐ Wear a hearing aid device
- ☐ Nose Bleeds
- ☐ Difficulty Speaking
- ☐ Recent hoarseness

- ☐ Heart Racing
- ☐ Heart Skipping beats
- ☐ Black out or fainting spells
- ☐ Feet/ankles swelling
- ☐ Hips or leg cramps when you walk less than 2 blocks
- ☐ Do you sleep on more than 1 pillow to help you breath at night?

- ☐ Stomach Ulcers
- ☐ Bleeding from your bowels or rectum
- ☐ Blood in your stools

- ☐ Varicose Veins
- ☐ Chronic Back Problems
- ☐ Arthritis
- ☐ Blood clots in your legs

- ☐ Stroke
- ☐ Temporary loss of vision
- ☐ Temporary inability to speak
- ☐ Temporary inability to move your arms
- ☐ Temporary inability to move your legs
- ☐ Seizures

- ☐ Depression
- ☐ Anxiety / Nervousness
- ☐ Attempted Suicide
- ☐ Use of illegal drugs

- ☐ High Cholesterol
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Bleeding disorder