

Name: _____ Date: _____

Referring MD: _____ DOB: _____ Age: _____

PCP: _____ Other MDs you see: _____

What is the primary reason you have come to Northwest Cardiovascular Center?

Are you having or have you ever had? (check all for which the answer is yes)

Increasing breathlessness with your usual activities

Shortness of breath at rest, lying down Recent cough

Heart attack Spells of rapid heartbeat

Pain, pressure / discomfort in the chest Palpitations

Any neck, jaw, left arm discomfort Passed (ing) out - fainting

Unexplained weight gain of more than 5 lbs. in the last weeks or months. Dizzy spells

Worsening fatigue Pain or cramps in leg(s) with walking

Swelling of the ankles A stroke or temporary stroke

Abnormal EKG Heart murmur

Have you been hospitalized for your heart or what they thought was your heart? Rheumatic fever

Any other cardiac diagnosis?

Any tests or surgeries done for your heart? What tests? _____

When and where were they done? _____

Have you ever been diagnosed with?

High blood pressure Yes No How long ago? _____

Diabetes Yes No How long ago? _____

High cholesterol Yes No

What medications do you take for this, if any

Lung disease Yes No What type? _____

When? _____

Blood vessel disease Yes No

Which vessels? _____

When? _____

Is there any family history of:

Heart attack Sudden death

Bypass surgery Hypertension

Angina Diabetes Clogged Arteries

Have you ever smoked? Yes No How many cigarettes per day? _____

How long (have) did you smoke(d)? _____

If you quit, when did you quit? _____

How many glasses per week do you consume of:

Wine _____ Beer _____ Cocktails _____

Where were you born? _____

What do/did you do for work? _____

Do you get regular exercise? Yes No What kind? _____

Marital Status: Single Married Divorced Widowed

List other medical problems you have had. These would include problems for which you have taken medications or been hospitalized. Please include the dates these problems occurred.

List all surgeries you have had and when and where they occurred:

Surgery	When	Hospital	Surgery	When	Hospital
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Please list all of your medications, include non-prescription drugs, dietary supplements and vitamins.

Name of drug	Dose	How many times each day
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Are you allergic to any medications? Yes No List those medications

Are you allergic to X-ray dye? Yes No

Other Allergies?

IS THERE ANY OTHER PROBLEM YOU WISH TO ADDRESS AT THIS VISIT?