

CARDIOVASCULAR CONSULTANTS MEDICAL GROUP

Consultative and Interventional Cardiology

Cardiac Electrophysiology

Peripheral Vascular Disease

A Partnership of Medical Corporations

www.healthyhearts.com

Ara G. Tilkian, M.D., F.A.C.C.
John S. Tsakonas, M.D., F.A.C.C.
M. Ganesa Pandian, M.D., F.A.C.C.
Leo Kassabian, M.D., F.A.C.C.
Shahe Garabedian, M.D., MS, F.A.C.C.
Ashish K. Aggarwal, M.D.
Shervin A. Sadrpour, M.D., F.H.R.S.

Isaac Wiener, M.D., F.A.C.C.
Kenneth K. Tam, M.D., F.A.C.C.
Ting S. Yee, M.D., F.A.C.C.
Adel K. El-Bialy, M.D., F.A.C.C.
Jayanta R. Das, M.D.
Abhishek Sinha, M.D., F.A.C.C.
Sarah McIndoe, N.P.



NAME: _____ DATE: _____

AGE: _____ DOB: _____ HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: S M W D SEP OCCUPATION: _____

HOW DID YOU HEAR ABOUT US? _____

REFERRING PHYSICIAN(S): _____

REASON FOR CONSULTATION: _____

CARDIAC HISTORY

PREVIOUS DIAGNOSIS OF HEART DISEASE _____ YES _____ NO

IF YES, PLEASE ELABORATE _____

SYMPTOM REVIEW: HAVE YOU BEEN TROUBLED BY

CHEST PAIN	_____ YES	_____ NO
SHORTNESS OF BREATH	_____ YES	_____ NO
PALPITATIONS	_____ YES	_____ NO
SWELLING OF ANKLES	_____ YES	_____ NO
DIZZINESS	_____ YES	_____ NO
FAINTING	_____ YES	_____ NO

HAVE YOU EVER HAD:

HEART MURMUR	_____ YES	_____ NO
HIGH BLOOD PRESSURE	_____ YES	_____ NO
HIGH CHOLESTEROL	_____ YES	_____ NO
DIABETES	_____ YES	_____ NO
HEART ATTACK	_____ YES	_____ NO
STROKE	_____ YES	_____ NO

PRIOR CARDIAC TESTS:	DATE	NORMAL	ABNORMAL
LAST ELECTROCARDIOGRAM	_____	_____	_____
LAST CHEST X-RAY	_____	_____	_____
LAST TREADMILL TEST	_____	_____	_____

PRIOR CARDIAC PROCEDURES: (INCLUDE ANGIOGRAPHY, ANGIOPLASTY, OPEN HEART, ETC., AS WELL AS PHYSICIANS, LOCATIONS, AND DATES IF POSSIBLE)

1. _____
2. _____
3. _____
4. _____

ANY COMPLICATIONS? _____

NON-CARDIAC HISTORY

DESCRIBE ANY OTHER MEDICAL CONDITIONS OR DIAGNOSES _____

PRIOR NON-CARDIAC PROCEDURES: (INCLUDE PHYSICIANS, LOCATIONS AND DATES IF POSSIBLE)

1. _____
2. _____
3. _____
4. _____

ANY COMPLICATIONS? _____

HABITS

SMOKING	_____ Never a smoker	_____ Previous smoker	_____ Current smoker/quantity? _____
ALCOHOL	_____ YES	_____ NO	DESCRIBE _____
EXERCISE	_____ YES	_____ NO	DESCRIBE _____
COFFEE	_____ YES	_____ NO	DESCRIBE _____
SPECIAL DIET	_____ YES	_____ NO	DESCRIBE _____

FAMILY HISTORY

IF LIVING: AGE/HEALTH

IF DECEASED: AGE/CAUSE OF DEATH

FATHER:	_____ / _____	_____ / _____
MOTHER:	_____ / _____	_____ / _____
BROTHER(S):	_____ / _____	_____ / _____
SISTER(S):	_____ / _____	_____ / _____

REVIEW OF SYSTEMS

COMMENTS

ANY WEIGHT CHANGE DURING THE PAST YEAR?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
HEADACHE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
COUGH?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
ABDOMINAL COMPLAINTS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
URINARY COMPLAINTS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
LEG PAINS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Do your legs ever feel tired, causing you to stop and rest? YES NO

When you walk do you ever have to stop because you have pain or cramping in your calves or thighs? YES NO

Do you ever experience cramping, tightness, "Charlie Horses" or pain in the legs and feet when lying down that improves when you stand up? YES NO

Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?
 YES NO

MEDICATIONS

DRUG	DOSAGE & FREQUENCY	DATE FIRST PRESCRIBED & PHYSICIAN
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

DESCRIBE ANY ALLERGIES

COMMENTS

DRUGS	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
IODINE OR CONTRAST AGENTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
OTHER ALLERGIES	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

FOR WOMEN ONLY

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____ MENOPAUSE: YES NO