CARDIOVASCULAR CONSULTANTS MEDICAL GROUP

Consultative and Interventional Cardiology
Cardiac Electrophysiology
Peripheral Vascular Disease

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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? _____ YES _____ NO _____

HEADACHE? _____ YES _____ NO _____

COUGH? _____ YES _____ NO _____

ABDOMINAL COMPLAINTS? _____ YES _____ NO _____

URINARY COMPLAINTS? _____ YES _____ NO _____

LEG PAINS? _____ YES _____ 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 _____ YES _____ NO _____

IODINE OR CONTRAST AGENTS _____ YES _____ NO _____

OTHER ALLERGIES _____ YES _____ NO _____

FOR WOMEN ONLY

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____ MENOPAUSE: _____YES _____NO