

Family History			
Member	Age		Medical Conditions (Please check all that apply and circle cause of death.)
Mother		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Irregular Heart Rhythm <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Stroke <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Sudden Death <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
Father		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Irregular Heart Rhythm <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Stroke <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Sudden Death <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
Sister		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Irregular Heart Rhythm <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Stroke <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Sudden Death <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
Brother		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Irregular Heart Rhythm <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Stroke <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Sudden Death <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Irregular Heart Rhythm <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Stroke <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Sudden Death <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Irregular Heart Rhythm <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Stroke <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Sudden Death <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
Review of Symptoms (Please check all of your current symptoms.)			
Cardiac	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations	<input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Syncope	<input type="checkbox"/> Shortness of breath lying flat <input type="checkbox"/> Shortness of breath that awakens you at night
Vascular	<input type="checkbox"/> Painful, aching, or tired feeling in legs while walking		<input type="checkbox"/> Swelling of ankles and feet
Constitutional	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fever
HEENT	<input type="checkbox"/> Visual Changes	<input type="checkbox"/> Hearing Loss	
Respiratory	<input type="checkbox"/> Snoring	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Shortness of Breath
Gastrointestinal	<input type="checkbox"/> Nausea	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Rectal Bleeding/Bloody Stool
Genitourinary	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Excessive Nighttime Urination	
Neurological	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Seizures
Psychiatric	<input type="checkbox"/> Depression	<input type="checkbox"/> Hallucinations	
Hematologic	<input type="checkbox"/> Acute Anemia	<input type="checkbox"/> Thrombocytopenia (low platelet count)	
Reproductive	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> History of Oral Contraception	
Endocrine	<input type="checkbox"/> Goiter	<input type="checkbox"/> Tremors	
Dermatologic	<input type="checkbox"/> Rash	<input type="checkbox"/> Skin Sores	
Musculoskeletal	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Muscle Pain	