

PATIENT HISTORY

PATIENT NAME _____ DATE _____ AGE _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- YES NO 1. Chest pain/angina?
If so, how often (daily/weekly/monthly)? _____
And how long does it last (minutes)? _____
What helps? _____
Also describe the pain. _____
- YES NO 2. Do you have shortness of breath?
- YES NO 3. Do you have nausea?
- YES NO 4. Do you have vomiting?
- YES NO 5. Do you get short of breath when walking?
- YES NO 6. Do you get short of breath when walking several blocks? How many? _____
- YES NO 7. Do you get short of breath when climbing flights of stairs? How many? _____
- YES NO 8. History of heart failure?
- YES NO 9. Any swelling of feet or legs?
- YES NO 10. Cramping of legs while walking?
- YES NO 11. Are you sensitive to extreme cold/heat?
- YES NO 12. Any numbness or tingling in legs?
- YES NO 13. Have palpitations/skipped heartbeats?
- YES NO 14. Any dizziness/blackouts/syncope/fainting/fatigue/rapid heart action?
15. How much physical activity do you do? _____
Types? _____
- YES NO 16. Do you have high blood pressure? When? _____
- YES NO 17. History of stroke? When? _____
- YES NO 18. Do you smoke? Number of packs a day? _____ How long? _____
- YES NO 19. Do you have high cholesterol?
- YES NO 20. Do you have diabetes? When? _____
- YES NO 21. Do you drink alcohol? How much? _____
- YES NO 22. Do you have Gout?
- YES NO 23. Do you have a lot of stress? Explain. _____
- YES NO 24. History of Rheumatic Fever? When? _____
- YES NO 25. If you are a woman, do you menstruate?
- YES NO 26. Previous EKG? When? _____
- YES NO 27. Have you ever had a Stress Test? When? _____
- YES NO 28. Have you ever had an Echocardiogram? When? _____
- YES NO 29. Have you ever had a Heart Catheterization? When? _____
- YES NO 30. Have you ever had Heart Surgery? When? _____
31. Do you have a family history of the following:
- | | Mother | Father | Brother | Sister |
|---------------------|--------|--------|---------|--------|
| Heart Disease | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ |
| High Cholesterol | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ |
32. Please list all medications: _____
33. Any allergies (medications, iodine, latex)? _____
34. Any other illness? _____

Please sign below to verify that this information is correct to the best of your knowledge:

Signature _____ Date _____