Southwest Cardiology
http://www.swcardiology.com

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Background

Name_____ Date of Birth:_____ Today's Date:_____

Primary Care Physician: _____

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other:_____

☐ Retired Most Recent/Current Occupation:_____ Exercise:_____

Cardiac Risk Factors (Check all that apply)

☐ Hypertension (high blood pressure) ☐ Diabetes ☐ High Cholesterol ☐ Overweight/Obesity

Tobacco (packs per day): ☐ Never ☐ <½ ☐ ½-1 ☐ 1-2 ☐ >2 ☐ Quit Smoking Date:_____

Alcohol (drinks per day): ☐ None ☐ <1 ☐ 1-2 ☐ 2-3 ☐ >3 ☐ Quit Alcohol Date: _____

Caffeine (drinks per day): ☐ None ☐ <1 ☐ 1-2 ☐ 2-4 ☐ >4

Personal Past Cardiac History (Check all that apply)

☐ ***Coronary Artery Disease*** ☐ Myocardial Infarction (Heart Attack) ☐ Angina

Most Recent Heart Catheterization (Date & Hospital)_____

☐ Coronary Stent (Dates) _____ ☐ Angioplasty (Dates)_____

☐ Cardiac Bypass Surgery (Date)_____ ☐ Last Stress Test (Date/Place)_____

☐ ***Congestive Heart Failure*** Last Hospitalization for Heart Failure (Date & Hospital)_____

Most Recent Echocardiogram (Date & Location):_____Ejection Fraction:_____

☐ ***Peripheral Vascular Disease*** ☐ Stroke ☐ Transient Ischemic Attack (Mini Stroke) ☐ Carotid artery disease

☐ Abdominal Aortic Aneurysm ☐ Leg Claudication (Pain with walking)

☐ Vascular Surgery (type, date, place)_____

Other:_____

Valvular Heart Disease Aortic Valve: ☐ Stenosis ☐ Regurgitation

Mitral Valve: ☐ Prolapse ☐ Regurgitation ☐ Stenosis ☐ Rheumatic Fever

☐ Valve Surgery (Type of Valve, Date, Hospital):_____

Other:_____

Heart Rhythm Disorder ☐ Palpitations ☐ Atrial Fibrillation ☐ Atrial Flutter ☐ WPW

☐ Heart Block ☐ Syncope (passing out) ☐ Pacemaker (Type, date)_____

☐ Ablation Procedure (Type, Date & Hospital):_____

Other Cardiac Disease ☐ Myocarditis ☐ Pericarditis ☐ Pericardial Effusion ☐ Pulmonary Hypertension

☐ Other:_____

Personal Past Medical History (Please check conditions currently treated or treated in the past)

Lung disease:	☐ Asthma ☐ COPD or emphysema ☐ Sarcoid disease
	☐ Sleep Apnea ☐ CPAP use ☐ Pneumonia
Neurological diseases:	☐ Migraine headaches ☐ Seizure disorder ☐ Neuropathy
Liver disease:	☐ Hepatitis ☐ Liver failure (cirrhosis) ☐ Gallstones
Gastrointestinal disease:	☐ Gastroesophageal reflux disease (heartburn) ☐ Peptic ulcer disease
	☐ Chronic diarrhea ☐ Constipation ☐ Irritable bowel syndrome
Kidney disease:	☐ Renal failure ☐ Hemodialysis or Peritoneal dialysis
Autoimmune disease:	☐ Osteoarthritis ☐ Gout ☐ Rheumatoid arthritis ☐ Lupus arthritis ☐ Scleroderma
	☐ Immune deficiency (HIV, AIDS, or other)
Hematologic disease:	☐ Anemia ☐ Bleeding disorder ☐ Deep vein thrombosis (DVT) ☐ Pulmonary embolus (PE)
Oncologic disease:	☐ Cancer (type)_____
Cancer treatments:	☐ Chemotherapy ☐ Radiation ☐ Surgery
Endocrine disease:	☐ Thyroid disease ☐ Cushing's disease ☐ Addison's disease
Ophthalmologic disease:	☐ Glaucoma ☐ Cataracts ☐ Macular degeneration
Psychiatric:	☐ Depression ☐ Anxiety ☐ Other:_____

Other Personal Medical History

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Personal Past Surgical history (Please list type of surgery, approximate year)

☐ Gallbladder _____ ☐ Appendix _____ ☐ Tonsils _____ ☐ Hernia _____

Surgery	***Year***	***Surgery***	***Year***

Medication Allergies: _____ _____ _____ _____ _____

Current Medications You may attach a separate list. Include herbal remedies, aspirin, and vitamin supplements.

Medication	***Dose***	***How often***

Family History (Please list immediate family members – parents, siblings, children)

	Deceased	Age (if deceased, age at death)	Heart attack	Heart Failure	Heart Bypass Surgery	Hypertension	Stroke	Other
Father	☐	_______	☐	☐	☐	☐	☐	____________
Mother	☐	_______	☐	☐	☐	☐	☐	____________
________	☐	_______	☐	☐	☐	☐	☐	____________
________	☐	_______	☐	☐	☐	☐	☐	____________
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________	☐	_______	☐	☐	☐	☐	☐	____________
________	☐	_______	☐	☐	☐	☐	☐	____________
________	☐	_______	☐	☐	☐	☐	☐	____________

Review of symptoms: Please check any symptoms you have had in the past 3 months

General:
- ☐ Change in appetite
- ☐ Persistent fever
- ☐ General fatigue
- ☐ General weakness
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Anxiety
- ☐ Depression

Eyes:
- ☐ Blurry vision
- ☐ Loss of vision
- ☐ Dry eyes

Ears, nose, mouth, throat:
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Nosebleeds
- ☐ Dentures
- ☐ Sore throat
- ☐ Hoarseness

Cardiovascular:
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Fainting/loss of consciousness
- ☐ Blue fingers or lips
- ☐ Varicose veins

Respiratory:
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Short of breath laying down

Endocrine:
- ☐ Adrenal disease
- ☐ Cortisone treatment

Genitourinary:
- ☐ Frequent daytime urination
- ☐ Frequent nighttime urination
- ☐ Pain or burning with urination
- ☐ (men) erectile dysfunction

Nervous system:
- ☐ Headaches
- ☐ Lightheadedness/dizziness
- ☐ Memory loss
- ☐ Weakness or paralysis

Gastrointestinal:
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Tarry stools
- ☐ Jaundice
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Difficulty swallowing

Skin:
- ☐ Rash
- ☐ Loss of pigmentation
- ☐ Itching
- ☐ Dry skin
- ☐ Easy Bruising
- ☐ Skin Ulcers

Musculoskeletal:
- ☐ Muscle cramps
- ☐ Pain in joints
- ☐ Swollen joints
- ☐ Stiffness