CARDIOLOGY EVALUATION – 1

Name:_____ **Date:**____/___/____
(First) (Middle) (Last)

Address:_____ **Telephone Home:**(___)_____
_____ **Office:**(___)_____

Date of Birth: ___/___/___ **Age:**____ **Birthplace**_____

Referred by: _____
Address: _____ Telephone #: (___)_____
_____ Fax #: (___)_____

Other Physicians:

_____

_____

Chief Complaint - Why are you here to see a Cardiologist?

_____

_____

Past Medical History - Do you have a history of: (if yes, please describe when)

- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Angina
- ☐ Heart Attack
- ☐ Irregular Heart Rhythm
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Fainting
- ☐ Vascular disease
- ☐ Other_____
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lung disease (asthma, emphysema…)
- ☐ Stomach or intestinal problems (ulcers, diverticulosis…)
- ☐ Liver disease
- ☐ Kidney disease (renal failure, stones…)
- ☐ Prostate problems
- ☐ Arthritis
- ☐ Cancer

_____

Prior Hospitalization(s)/Surgeries

Why? Where? When?

_____

_____

_____

_____

_____

OVER ⇒

Family History:

Father: ☐Alive Age____ ☐ Deceased Age_____ Medical Problems:_____

Mother: ☐ Alive Age____ ☐ Deceased Age_____ Medical Problems:_____

Brothers/Sisters: (please circle brother or sister in the space provided)

Brother/Sister ☐ Alive Age____ ☐ Deceased Age_____ Medical Problems:_____

Brother/Sister ☐ Alive Age____ ☐ Deceased Age_____ Medical Problems:_____

Brother/Sister ☐ Alive Age____ ☐ Deceased Age_____ Medical Problems:_____

Brother/Sister ☐ Alive Age____ ☐ Deceased Age_____ Medical Problems:_____

Brother/Sister ☐ Alive Age____ ☐ Deceased Age_____ Medical Problems:_____

Personal History:

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Children: Sons_____ Daughters_____

Smoking: Do or did you smoke? ☐ Yes, currently. ☐ Yes, in the past ☐ Never

How many packs per day_____ For how long?_____

When did you stop?_____

Alcohol: ___ glasses of wine, drinks hard liquor or beers/day

Caffeine: ___ cups of coffee per day ____ cups of tea per day ___ glasses of soda per day

*Exercise:*_____

*Hobbies:*_____

*Occupation:*_____

Current Medications:

Drug Name:	Strength:	How many per day?

Drug Side Effects or Allergies

Drug Name:	Reaction:	When?