Name

Date

PATIENT HISTORY

1. CURRENT INFORMATION

A. Who was kind enough to refer you to us?

B. What is the primary purpose of your visit today?

For Office Use CC:

For Office Use
HPI:

2. PAST CARDIAC HISTORY

A. Have you had any previously documented history or heart problems?

B. If so, please outline as best you can the chronologic order of your cardiac history (e.g. heart attack in 1990, stent in 1992, bypass operation in 1994)

C. Are you currently having any symptoms which you feel may be cardiac in nature (e.g. chest discomfort, shortness of breath, palpitations or unusual heart beats, lightheadedness or losing consciousness)

D. Have you had any of the following: history of cigarette smoking, hypertension (high blood pressure), elevated cholesterol, diabetes, family history of stroke or heart attack under the age of 55?

For Office Use:
Cardiac History:

Risk Factors +
-

3. PAST MEDICAL HISTORY

A. Please list your medical illnesses (current or prevous)

B. Please list your surgical procedures

4. PLEASE LIST YOUR MEDICATIONS

5. PLEASE LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC

6. FAMILY HISTORY

A. Are your parents living or deceased.? If deceased, please indicate age and cause of death if you know:

Father

Mother

B. Is there a family history of premature (under age 55) heart attack or stroke?

C. Is there a family history of unexplained sudden death?

7. PERSONAL AND SOCIAL HISTORY

A. Are you married?

B. How many children to you have?

C. Where are you from originally?

D. If you are working, what is your occupation?

E. Do you smoke cigarettes?

Yes, _____ per day

Never

Previously. If previously, how much did you smoke and how long ago did you stop?

F. Do you drink alcohol? If so, how much?

8. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

For Office use:

Exam:

ECG:

Additional Data:

Assessment:

Plan: