PHILIP REID ORANBURG, M.D., P.A.
CARDIOVASCULAR MEDICINE

PHILIP R. ORANBURG, M.D., F.A.C.C.

PATIENT QUESTIONAIRE

PATIENT NAME______________________________
REFERRING DOCTOR ______________________________
REASON FOR REQUEST FOR STRESS TEST________________

Please list all current medications:______________________________
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Please note any medication allergies______________________

Please check any of the following conditions, diseases, illnesses, procedures or surgery you currently have or have had in the past.

____**Heart Attack**
____**Congestive Heart Failure**
____**Irregular Heart Beat**
____***Mitral Valve Prolapse***
____**Heart Murmur**
____**Palpitations**
____**Chest Pain(angina)**
____**Diabetes**
____**High Blood Pressure**
____**Bypass Surgery**
____**Angiogram**
____**Angioplasty**
____**Stroke**
____**Asthma**
____**Emphysema**
____**Shortness of Breath**
____**Dizziness**
____**High Cholesterol**
____**Family history of heart disease**
____**Peripheral Vascular Disease**

Please list other major medical problems and previous surgical procedures:
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____
____

Please check any of the following HABITS you currently have or had in the past:

Smoking______________ **Alcohol Consumption**______________

PATIENT SIGNATURE______________________________

GLADES MEDICAL PLAZA
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