

Parkside Cardiology

NAME: _____ DOB: _____ AGE: _____ SEX: _____ DATE: _____

HEIGHT: _____ WEIGHT _____ REFERRING DR: _____

What is your main reason for seeing a cardiologist? _____

Do you have any previous cardiac problems and how were they treated (including angioplasty or heart surgery)? _____

Previous heart tests: Stress test _____ Echocardiogram _____ Holter Monitor _____ Cardiac Catheterization _____

Have you had any of the following:

High blood pressure _____	If yes, how long? _____ years treated _____	which meds? _____
Diabetes _____	If yes, how long? _____ years treated _____	which meds? _____
High cholesterol _____	If yes, how long? _____ years treated _____	which meds? _____

	Yes/No	When		Yes/No	When
Heart Attack	____/____	_____	Heart Murmur	____/____	_____
Chest Pain (Angina)	____/____	_____	Mitral Valve Prolapse or leak	____/____	_____
Shortness of breath (exertional)	____/____	_____	Rheumatic Fever	____/____	_____
Cough/Recent respiratory infection	____/____	_____	Heart valve infection	____/____	_____
Chest injury/trauma	____/____	_____	Mini-stroke or stroke	____/____	_____
Congestive heart failure	____/____	_____	Claudication (leg pain)	____/____	_____
Leg Swelling (edema)	____/____	_____	Deep vein thrombosis	____/____	_____
Shortness of breath at rest/night	____/____	_____	Bleeding problems/anemia	____/____	_____
Need for extra pillows to sleep	____/____	_____	Asthma/chronic bronchitis	____/____	_____
Heart rhythm problems	____/____	_____	Ulcers or reflux	____/____	_____
Palpitations	____/____	_____	Abdominal pain	____/____	_____
Dizziness	____/____	_____	Nausea/vomiting/diarrhea	____/____	_____
Fainting	____/____	_____	Kidney problems	____/____	_____
Thyroid disease	____/____	_____	Liver problems	____/____	_____

Any additional past illnesses: _____

Past surgery: _____

Allergies to medications: _____ **Allergy to iodine/contrast dye?** _____

Medications:

<u>Name</u>	<u>Dose</u>	<u>Times per day</u>

Mother living? Yes/No If yes, any present illness _____
 If no, age of death _____ died of _____
 Father living? Yes/No If yes, any present illness _____
 If no, age of death _____ died of _____

Personal History:

Occupation _____
 Exercise Frequency _____
 Type of diet _____
 Alcohol (drinks/day) _____ Caffeine (drinks/day) _____
 Smoking? _____ If yes, packs per day _____ Years _____
 If past, year stopped _____ packs per day _____ yrs _____
 Illicit drug use Y N _____
 (Women only) Postmenopause? _____ Year _____

Family History:

Heart Attack _____ Stroke _____
 Hypertension _____ Diabetes _____
 Siblings _____ Age _____ Health _____
 _____ Age _____ Health _____
 _____ Age _____ Health _____
 _____ Age _____ Health _____
 _____ Age _____ Health _____
 _____ Age _____ Health _____
 Any deceased? Age _____ Cause _____
 _____ Age _____ Cause _____

Signature of person submitting information: _____

Relationship to patient (if applicable): _____