Thank you for making an appointment with Legacy Heart Center.

Please complete **ALL** questions to the best of your ability.

Name: _____ Family Dr. (PCP):_____

Date of Birth: _____ Marital Status: _____

Reason for visit: _____ Occupation: _____

Who referred you to us: _____ Children: None ___ son(s) ___ daughter(s)

1. Are you diabetic? ☐ **No** ☐ **Yes,** for how long?
2. Do you have high blood pressure? ☐ **No** ☐ **Yes,** for how long? Average BP: _____
3. Do you have high cholesterol? ☐ **No** ☐ **Yes,** for how long?

   Last known cholesterol reading: Total _____ HDL _____ LDL _____ Trigs _____
4. Circle any other past illnesses/problems that you have been treated for:

Emphysema	Asthma	Sleep Apnea	TB	Heart Murmur
Hiatal Hernia	Ulcer	Reflux	Hepatitis	Liver Disease
Stroke	Seizures	Depression	Kidney Disease	Atrial Fibrillation
Hypothyroid	Heart Attack	Coronary Disease	Peripheral Disease	Carotid Disease

   OTHER: _____
5. Are you pregnant? ☐ **No** ☐ **Yes,** due date:_____ Last Menstrual Cycle:_____

   Have you gone through menopause or had a hysterectomy? ☐ **No** ☐ **Yes**
6. Are you here for surgical clearance? ☐ **No** ☐ **Yes**
   Date: _____ For: _____ Surgeon: _____

SURGERIES (including pacemaker implants)

Type	***Date***	***Location***	***Surgeon***

OTHER RECENT HOSPITAL VISITS

	Date	***Hospital***

Smoking Status: ☐ Never ☐ Former Started: _____ ☐ Daily Quit: _____ ☐ Some Days Packs/Day: _____

Alcohol Use: ☐ Never ☐ Socially ☐ Per/Day _____ ☐ Quit Drinking

Caffeine Use: ☐ Rare ☐ Sometimes ☐ Heavy

Drug Use: ☐ Never ☐ Former ☐ Current

☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other _____

Exercise: ☐ Never ☐ Some Days ☐ Most Days ☐ Daily

CARDIAC TESTING	*Date*	*Location*	*Specific Type*	*Result*
Lab work				
EKG				
Chest X-Ray				
Echocardiogram				
Stress Test				
Holter/Event Monitor				
EP Study				
Cardiac Catheterization				
Coronary Bypass Surgery				
Other:				

FAMILY HISTORY Any known family history of HEART disease? ☐ NONE ☐ ADOPTED ☐ UNKNOWN

	Heart Problem	*Age Diagnosed*	*Age Deceased*
Mom			
Dad			
Brother			
Sister			
Other:			

MEDICATIONS - List ALL prescription medicines, over the counter medicines, herbs any supplements:

Name	*Dosage*	*Frequency*	*Date Started*

ALLERGIES - List any allergies to medications or foods:

_____

_____

_____

PREFERED PHARMACY - _____

RECENT SYMPTOMS

General

- ☐ Appetite Loss
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Generalized Weakness
- ☐ Weight Loss

Eyes

- ☐ Discharge
- ☐ Halos
- ☐ Irritation
- ☐ Recent Visual Changes

ENT

- ☐ Allergy/Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Disruptive Snoring
- ☐ Ear Ache
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Post Nasal Drip
- ☐ Runny Nose
- ☐ Sneezing
- ☐ Voice Change

Musculoskeletal (MS)

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Aches

GI

- ☐ Abdominal Bloating
- ☐ Change in bowels
- ☐ Difficulty swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heart Burn/Indigestion
- ☐ Black stools (melena)
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting

Psychological

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia

Endocrine

- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Temperature Intolerance
- ☐ Tremors Feelings of Anxiety

Skin (Derm)

- ☐ Acne
- ☐ Hair Loss
- ☐ Nail Problems
- ☐ Pruritus
- ☐ Rash
- ☐ Suspicious Lesions

Neurological

- ☐ Uncoordinated muscle movements (ataxia)
- ☐ Double Vision (diplopia)
- ☐ Frequent Falls
- ☐ Headaches
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Sudden Loss of Vision
- ☐ Tremors

Hematology (Heme)

- ☐ Abnormal Bleeding
- ☐ Bruises Easily
- ☐ Enlarged Lymph Nodes

OTHER DOCTORS THAT YOU SEE:

_____

_____

_____

_____

SPECIFIC CARDIAC SYMPTOMS:

1. Do you experience any chest pain/discomfort? ☐ No ☐ Yes

Where is it located? _____

How does it feel? ☐Aching ☐Burning ☐Sharp ☐Stabbing ☐Dull Pressure

How severe is it (circle)? 1 2 3 4 5 6 7 8 9 10 (worst)

How often does it occur? _____

How long does it last? _____

What makes it worse? ☐Activity ☐Stress ☐Rest ☐Deep Breaths ☐Other:_____

What makes it better? ☐Rest ☐Nitro ☐Position Changes ☐Other:_____

When did it last occur? _____

List any associated symptoms that occur with it: _____

2. Do you experience any shortness of breath not associated with chest pain? ☐ No ☐ Yes

When do you get short of breath? ☐ With Activity ☐At Rest ☐Other:_____

How often does it occur? _____

Do you need to sleep on more than 1 pillow to breathe? ☐ No ☐ Yes, How many pillows? _____

Do you wake up in the middle of the night short of breath? ☐ No ☐ Yes

Do your ankles swell? ☐ No ☐ Yes, When?_____

What makes it better? _____

List any associated symptoms that occur with it:_____

3. Do you experience any palpitations (rapid or skipped heart beats)? ☐ No ☐ Yes

When does it occur? _____

How often does it occur? _____

How long does it last? _____

When did it last occur? _____

4. Have you felt like you almost pass out? ☐ No ☐ Yes

Have you *actually* passed out (lost consciousness)? ☐ No ☐ Yes

What were you doing when this occurred? _____

List any other symptoms that you had when this occurred: _____

How many times has it occurred? _____

When did it last occur? _____

5. Any other reason why you need to see a cardiologist?

_____

_____

_____

_____.