HEART CENTER

FIRST VISIT INTERVIEW

NAME		DOB	

Reason for Referral:

ALLERGIES (Please list all medication and food allergies and what the reaction was)

1		5	
2		6	
3		7	
4		8	

MEDICATIONS (Please include vitamins and herbal supplements)

	Name	Dosage	#Times/Day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

SYMPTOMS (Please check yes or no accordingly)

Symptom	YES	NO	Symptom	YES	NO
Chest Pain/Ache/Tightness			Dizziness		
With exertion			Near Loss of Consciousness		
After a meal			Loss of Consciousness		
Alleviates with rest			Edema		
Alleviates w/ Nitro			Alleviates with elevation		
Accompanied by nausea			Alleviates with limiting salt		
Accompanied by sweating			Chronic		
Shortness of Breath			Palpitations		
With effort			Chronic		
At rest			Accompanied by dizziness		
When lying flat			Lasting >1 min per episode		
Cough			Exacerbated by caffeine		
With sputum			Exacerbated by alcohol		
With blood			Exacerbated by exertion		

FAMILY HISTORY

Condition	Yes	No	Family Member
Heart Attack			
Hypertension			
Sudden Death			
Stroke			
Diabetes			

RISK FACTORS

Condition	Yes	No	Comments
Hypertension			Age of onset:
Smoking			Ppd: #yrs: Quit:
Diabetes			Age of onset:
High Cholesterol			
Family History of (circle)			Bypass Stent Angina

NAME		DOB	

MEDICAL HISTORY

Condition	YES	NO	Condition	YES	NO
Heart Attack			Renal Failure		
Angina/Chest Pain			Kidney Stones		
Arrhythmia			Blood in Urine		
Murmur			Migraine		
Rheumatic Fever			Muscle weakness		
Aneurysm			Vertigo		
Peripheral Vascular Disease			Numbness		
Congenital Heart Defect			Thyroid Disease		
Heart Failure			Sexual Dysfunction		
Stroke/TIA			Weight Loss		
Diabetes Mellitus			Fever		
Heartburn			Loss of Appetite		
Stomach Ulcer/GI Bleeding			Arthritis		
Tuberculosis			Back Pain		
Asthma			Hepatitis		
COPD			Cancer		
Pneumonia			Type: chemo radiation		

SURGICAL HISTORY

Surgery	Y	N	Date	Surgery	Y	N	Date
Coronary Bypass				Pacemaker			
Coronary Stent				Defibrillator (ICD)			
Cardiac Ablation				AAA Repair			
Heart Valve Replacement				Joint Surgery			

Please list any other hospitalizations or surgeries below:		Date
1		
2		
3		

PREVIOUS CARDIAC TESTING

Test	Y	N	Date	Test	Y	N	Date
Cardiac Catheterization				Echo (ultrasound)			
Stress Test				Holter			
EKG/ECG				Chest x-ray			

SOCIAL HISTORY

Living Situation: □ Alone □ With Spouse □ With Family Member □ With Friend □ Other_____

Diet: □ Healthy □ Vegetarian □ Low Fat □ Low Salt □ Avoid red meat □ Diabetic □ No limitation

Activity Level:
□ Sedentary □ Light □ Moderate □ Vigorous
Frequency of Activity
□ Daily □ Frequently □ Occasionally □ Rarely
Activities:

Alcohol:
Type
□ Wine □ Beer □ Liquor
Frequency
□ Daily □ Frequently □ Occasionally □ Rarely
□ Socially

Caffeine:
Type
□ Coffee □ Tea □ Soda □ Chocolate
Frequency
□ Daily □ Frequently □ Occasionally □ Rarely

Drug Abuse: □ Yes □ No (If yes, continue)
□ Marijuana □ Cocaine □ Heroin □ Opioids
□Other _____
Frequency:
□ Daily □ Frequently □ Occasionally □ Rarely
□ Socially
Quit: □ Yes □ No Date _____