

Social History

Marital Status: Divorced Married Single Widowed Life Partner Other: _____

Do you have children: No Yes **If Yes,** Number of sons: _____ Number of daughters: _____

Race: White Black/ African American Hispanic/ Latino American Indian/ Alaska Native Asian
 Pacific Islander/ Native Hawaiian Other: _____ Declined

Do you follow a specific Diet: (check all that apply)

Diabetic Low Carb Low Fat, Low Chol Low Salt No Added Salt No specific diet

Regular Renal Vegetarian Weight Loss Other: _____

Activity Level (exercise): Sedentary Occasional Regular Active Life Style Physically Unable to Exercise

Exercise Type: (check all that apply) **Frequency:** _____ (times per week)

Aerobics Cycling Dancing Elliptical Jogging Physical Therapy Running Swimming

Team Sports Walking Weight lifting Other: _____

Do you consume Alcohol: Yes No Former **If Yes, What Type:** Beer Wine Liquor

If Yes, Frequency: Rarely Frequently Social Occasional Daily **Drinks per week:** _____

Do you consume Caffeine on a daily basis: Yes No **Cups per day:** _____

If Yes, What type: Chocolate Coffee Energy Drink Soda Tablets Tea Other: _____

Drug use/Abuse: Yes No Former **If Yes, What type:** _____

Advanced Directives: None DNR HC Proxy Living Will

Primary Language: English Spanish

Family History

Unknown- (Unknown)Family Hx

Adopted - (Unknown)Family Hx

Place a check mark in the box for any conditions below that apply:

RELATIONSHIP TO PATIENT:	MOTHER	FATHER	SISTER	SISTER	BROTHER	BROTHER	OTHER:
CURRENT AGE:							
AGE AT DEATH:							
HEART ATTACK:							
ARRHYTHMIA:							
HEART FAILURE:							
ANEURYSM:							
STROKE (CVA):							
HIGH BLOOD PRESSURE:							
HIGH CHOLESTEROL:							
DIABETES:							
LUNG DISEASE:							
RENAL DISEASE:							
CANCER:							
Type: _____							

Other pertinent family history:

Past Medical History*Place a check mark in the box for any of the conditions that apply:***Respiratory:** COPD Pulmonary Embolus Pulmonary Hypertension Sleep Apnea Other: _____**Renal:** End Stage Renal Disease Renal Artery Stenosis Renal Insufficiency Other: _____**Endocrine:** Hyperthyroidism Hypothyroidism Obesity Other: _____**Oncology:** Breast Cancer Skin Cancer Lung Cancer Prostate Cancer Other: _____ Chemotherapy Radiation Other: _____**Cardiac:** Arrhythmias Congestive Heart Failure CAD Heart Attack (MI) Valvular Heart Disease CABG (Bypass) Coronary Stent ICD Pacemaker PTCA (Angioplasty) Other: _____**Vascular:** Abdominal Aneurysm Peripheral Arterial Disease Carotid Disease DVT Thoracic Aneurysm Varicose Veins Amputation Aneurysm Repair Vein Stripping Other: _____**List any other medical conditions:**

List any other surgeries:

Cardiac Testing	Yes	No	Date or Year	Location or Hospital	Additional Comments
Echo (ultrasound):	<input type="checkbox"/>	<input type="checkbox"/>			
Electrophysiology:	<input type="checkbox"/>	<input type="checkbox"/>			
Cath Lab:	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular:	<input type="checkbox"/>	<input type="checkbox"/>			
Stress Test:	<input type="checkbox"/>	<input type="checkbox"/>			
CT/MRI:	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			

Any other cardiac testing:

Review of Symptoms

Check only the problems you are currently experiencing:

	Y	N		Y	N	
Cardiac:	<input type="radio"/>	<input type="radio"/>	Chest Pain (pressure) Palpitation (fluttering) Orthopnea (trouble breathing lying down)	<input type="radio"/>	<input type="radio"/>	Diaphoresis (excessive perspiration) Syncope (loss of consciousness) PND (trouble breathing at night)
Vascular:	<input type="radio"/>	<input type="radio"/>	Claudication (leg pain)	<input type="radio"/>	<input type="radio"/>	Edema (swelling)
Constitutional:	<input type="radio"/>	<input type="radio"/>	Weight Gain Fever	<input type="radio"/>	<input type="radio"/>	Weight Loss
HEENT:	<input type="radio"/>	<input type="radio"/>	Visual Changes	<input type="radio"/>	<input type="radio"/>	Hearing Loss
Respiratory:	<input type="radio"/>	<input type="radio"/>	Snoring Dyspnea (shortness of breath)	<input type="radio"/>	<input type="radio"/>	Hemoptysis (coughing up blood)
Gastrointestinal:	<input type="radio"/>	<input type="radio"/>	Nausea Bleeding	<input type="radio"/>	<input type="radio"/>	Reflux
Genitourinary:	<input type="radio"/>	<input type="radio"/>	Hematuria (blood in urine)	<input type="radio"/>	<input type="radio"/>	Nocturia (nighttime urination)
Neurology:	<input type="radio"/>	<input type="radio"/>	Dizziness Seizures	<input type="radio"/>	<input type="radio"/>	Memory Loss
Psychiatric:	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Hallucinations
Hematologic:	<input type="radio"/>	<input type="radio"/>	Acute Anemia	<input type="radio"/>	<input type="radio"/>	Thrombocytopenia (low platelet count)
Endocrine:	<input type="radio"/>	<input type="radio"/>	Goiter (enlarged thyroid)	<input type="radio"/>	<input type="radio"/>	Tremors
Derm (Skin):	<input type="radio"/>	<input type="radio"/>	Rash	<input type="radio"/>	<input type="radio"/>	Skin Sores
Musculoskeletal:	<input type="radio"/>	<input type="radio"/>	Joint Pain	<input type="radio"/>	<input type="radio"/>	Myalgia (muscle pain)

Any additional symptoms you are experiencing:

Patient Name (printed): _____ Date: _____