

Thank you for making an appointment with Legacy Heart Center. Please complete **ALL** questions to the best of your ability. If a question does not apply to you, please mark "N/A" for not applicable.

NAME: _____ Date of scheduled visit: _____
 DOB: _____ SSN# _____ - _____ - _____ Family Dr. (PCP) : _____

Marital Status: _____ Occupation: _____ Children: None ___ son(s) ___ daughter(s)

Reason for Visit: _____ Who referred you to us? _____

Were you recently in the ER/Hospital? **NO YES** Date _____ Reason _____ Hospital _____

Are you having surgery? **NO YES** Type of Surgery _____ Surgeon _____ Date: _____

Previous Cardiac Testing? **NO YES** (please answer below)

Labwork: Date: _____ Where? _____ Result _____	EKG: Date: _____ Where? _____ Result _____	Chest X-Ray: Date: _____ Where? _____ Result _____	Echo: Date: _____ Where? _____ Result _____
Regular Stress Test: Date: _____ Where? _____ Result _____	Nuclear Stress Test: Date: _____ Where? _____ Result _____	24 Hr Holter Monitor: Date: _____ Where? _____ Result _____	Heart Cath: Date: _____ Where? _____ Result _____
Stent: Date: _____ Where? _____ Result _____	Angioplasty: Date: _____ Where? _____ Result _____	Bypass Surgery: Date: _____ Where? _____ Result _____	EP Study: Date: _____ Where? _____ Result _____

• **Surgeries**---list all operations you have had and the dates of surgeries

TYPE OF SURGERY	DATE	LOCATION	SURGEON

• **Hospital Admissions**---other than surgeries, list any admission to the hospital

REASON FOR ADMISSION	DATE	HOSPITAL

• **Previous Illnesses** --- Are you or have you been treated for previous illnesses/problems?

Diabetes **NO YES** How long have you been diabetic? _____
 High Blood Pressure **NO YES** How long have you had high blood pressure? _____
 Average BP Reading: _____
 High Cholesterol **NO YES** How long have you had high cholesterol? _____
 Last known cholesterol reading: Total ____ HDL ____ LDL ____ Trigs ____

Circle any other past illnesses/problems that apply:

- | | | | |
|---------------|-----------|-----------------|----------------|
| Hiatal Hernia | Asthma | Heart Attack | Sleep Apnea |
| Heart Murmur | Emphysema | Hyperthyroidism | Kidney Disease |
| TB | Ulcer | Hypothyroidism | Reflux |
| Hepatitis | Stroke | Seizures | Depression |
| Other: _____ | | | |

Are you pregnant? **NO YES** Due date: _____ Last Menstrual Cycle: _____

Have you gone through menopause or had a hysterectomy? **NO YES**

- **Allergies**—list any allergies to medications or foods and the reaction:

Do you use or have you ever used tobacco? NO YES	Type? Cigarettes Cigars Pipes Chewing Tobacco	How much? _____ per day _____ per week _____ per month _____ per year	When did you start? _____ When did you quit? _____
Do you use or have you ever used alcohol? NO YES	Type? Beer Wine Liquor Spirits	How much? _____ per day _____ per week _____ per month _____ per year	Describe your use: Social Drinker Binge Drinker Moderate Drinker Alcoholic Quit Drinking _____ ago
Do you use any recreational drugs? NO YES	What drugs do/did you use? _____ _____ _____	How much? _____ per day _____ per week _____ per month _____ per year	When did you start? _____ When did you quit? _____ Treatment/Rehab?
Do you exercise on a regular basis? NO YES	Type? _____ _____ _____	How long do you exercise? _____ How often? _____	Circle any applicable: Just started exercising Exercise inconsistently Unable to exercise due to: _____
Do you use caffeine? NO YES	Caffeinated Coffee? ___ cups per day/wk/mo/yr Caffeinated Tea? ___ cups per day/wk/mo/yr	Soda/cola? _____ per day/wk/mo/yr	Chocolate? _____ servings per day/wk/mo/yr
Are you on a special diet? NO YES	What type? Low Fat Low High Protein Atkins Salt Vegetarian ADA Exchanges American Heart Assoc. Southbeach Other: _____	How well do you follow? Strictly Usually Occasionally Non-compliant with diet	

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

Family Member	Heart Problem	Age Problem Started	Age Family Member Died
Mom			
Dad			
Brother			
Brother			
Sister			
Sister			
Son			
Daughter			
Other _____			

CURRENT CARDIAC SYMPTOMS

1. Do you experience any chest pain/discomfort? NO YES

Where is your pain located? _____

How would you describe your chest pain? Aching Burning Sharp Stabbing Dull Pressure
Does your pain travel to another location? NO YES, Where? _____

How severe is your chest pain? Circle one: 1(minor) 2 3 4 5 6 7 8 9 10 (intense)
How often do you get this chest pain? _____ times per day week month
How long does this chest pain last? _____ seconds minutes

What brings on this chest pain? Activity Stress At Rest Deep Breath Other: _____
What relieves this chest pain? Rest Nitro Change in Position Other: _____
When was your last episode of chest pain? _____

List any associated symptoms that occur with chest pain: _____

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 do you get short of breath? _____ times per day week month

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? _____

Does anything relieve your shortness of breath? NO YES, _____

List any associated symptoms that occur with shortness of breath: _____

3. Do you experience any palpitations (rapid heart beat or skipped beats)? NO YES

When do you get these palpitations? _____

How often do you get these palpitations? _____ times per day week month
How long do these palpitations last? _____ seconds minutes hours
When was your last episode of palpitations? _____

4. Have you ever felt like you were going to pass out? NO YES

Have you ever actually passed out (lost consciousness)? NO YES

What were you doing when this occurred? _____

Did you have any other symptoms with this episode? NO YES, What? _____

How often does this happen? _____ times per day week month infrequently

When was your last episode? _____

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

