

CLINICAL INFORMATION

Please Complete and Bring to Your Office Visit

Name: _____	Appointment
Date: _____	
Date of Birth: _____	Age: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

Reason for Today's Office Visit: _____

List of Medications:

Medication	Strength/Dose	Medication	Strength/Dose

Are you allergic to any medications? If so, list: _____

Are you allergic to iodine or seafood? Yes No

Have you ever had a reaction to iodine or IV contrast? Yes No

IN EACH SECTION BELOW PLEASE CHECK ALL THAT APPLY TO YOU

History of Present Illness					
Have you recently experienced:	Yes	No	Have you recently experienced:	Yes	No
Chest Pain/Pressure, Tightness, Heaviness			Irregular Heart Beat		
Dizziness, Passing Out, Fainting			Swelling - where		
Shortness of Breath			Pain in Legs with Exercise		
Past Medical History					
Abdominal Aneurysm			Congestive Heart Failure/Fluid in Lungs		
Asthma			Depression		
Anemia			Diabetes		
Anxiety			Emphysema/COPD/Lung Problems		
Arthritis			GERD /Acid Indigestion		
Cancer- Breast			Gout		
Cancer – Bladder			Hiatal Hernia		
Cancer – Colon			Kidney Disease		
Cancer – Liver			Leg or Hip Cramps		
Cancer – Lung			Liver Disease		
Cancer – Pancreas			Menstrual Problems		
Cancer – Prostate OR Prostate Enlargement			Neck : large artery blockage		
Cancer – Stomach			Parkinson's Disease		
Cancer - Uterus			Seizures		
Cancer – Skin			Stomach Ulcer or Bleeding Ulcer		
Colitis			Stroke with or without Paralysis		
Congenital Heart Disease			Thyroid Problems		

Past Cardiac History

Chest Pain (Angina)		High Cholesterol	
Congestive Heart Failure		Hypertension	
Heart Murmur / Valve Disease		Atrial Fibrillation (irregular heart beat)	
Heart Attack: How Many?		Blockage of heart arteries (coronary artery disease)	

Date(s) of Heart Attack(s):

Infection History

Hepatitis		Mumps	
Measles		Rheumatic Fever	
HIV +		TB (Tuberculosis)	
Other:			

Trauma History

Cardiac Contusion		Stab Wound	
Major/Minor Burns		Traumatic Amputation	
Multiple Fractures due to Auto Accident		Concussion/Skull Fracture	
Gunshot Wound		Other:	

Surgical History

Heart Valve Replacement <input type="checkbox"/> Mitral <input type="checkbox"/> Aortic		Pacemaker / ICD Implant	
Carotid Artery Surgery (neck)		Hip Replacement	
Breast Surgery		Lung Surgery	
Heart Bypass Surgery How Many? _____		Knee Replacement	
Date(s)		Thyroid Surgery	
Cataract Removal		Prostate Surgery (TURP)	
Gallbladder Removal		Hysterectomy	
Hemorrhoid Surgery		Gastric Bypass/Lapband/Stomach Stapling	
Other			

Vascular Procedures

Femoral/Popliteal Bypass Surgery: Right Left Bilateral

Angioplasty or Stent in Legs: Right Left Bilateral

Cardiac Procedures

Heart Catheterization How Many?		Heart Cath Dates :	
EP Study (Electrophysiology)		Ablation	
PTCA (Balloon Angioplasty) How Many?		PTCA Dates:	
Stent (wire coil) placed in heart artery How Many?		Stent Dates:	
Kidney / Renal Procedures		Echocardiogram	
Event Monitor		Holter Monitor	
Cardioversion		Stress Test	

Cardiac Risk Factors

Smoke Cigarettes currently How Much? How Long?		Diabetes	
Used to Smoke but quit		Previous Heart Disease	
Family History of Heart Disease		History of Obesity	
High Cholesterol		Reached Menopause	
High Blood Pressure		Take Hormones	

Social History/Other Cardiac Risk Factors

Drink Alcohol Regularly		No Regular Exercise	
Drink Alcohol Occasionally/Socially		Some Exercise	
Smoke Currently		Exercise Regularly	
Used to Smoke but Quit		Single	
Eat a Low Salt/ Low Cholesterol Diet		Married	
Low Fat Diet		Divorced	
Diabetic Diet		Widow / Widower	
No Diet Modifications		Caffeine Use: Coffee, Soda Tea: How Much?	

Family History

Heart Problems:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
High Blood Pressure:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Stroke:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Cancer:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Glaucoma:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Diabetes:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Seizures:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Problems Bleeding:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Kidney Problems:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Thyroid Disease:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles
Mental Illness:	Father	Mother	Grandparents	Child	Brother	Sister	Aunts/Uncles

Review of Systems

Do you get short of breath when you walk or exercise?		Hip or leg cramps when you walk less than 2 blocks?	
Do you sleep on more than 1 pillow to help you breathe at night?		Do you wake up from sleep having trouble breathing?	
Recent weight loss		Current blood or mucus in stools?	
Recent weight gain		Stomach ulcers	
Fever / chills		Arthritis	
Decreased exercise tolerance		Blood clots in legs	
Wear glasses / contacts		Varicose veins	
Partial vision loss		Stroke	
Cataracts currently		Stroke with paralysis	
Glaucoma		Anxiety / nervousness	
Hearing loss		Depression	
Nose bleeds		Use of illegal drugs	
Difficulty speaking		Attempted suicide	
Emphysema (COPD)		High Cholesterol	
Thyroid Problems		Allergy to Foods	
Diabetes		Bleeding disorders	
Heart Racing		Seasonal allergies	
Have you recently had chest pains		Allergy to medications	
Heart skipping beats		Urinary or bowel problems	
Feet / Ankle swelling		Blackout or fainting spells	