

Activity Level: which of the following best describes your level of physical activity both in your daily life and your leisure time

- Exercise strenuously on a regular basis
- Exercise moderately on a regular basis
- Exercise on an occasional basis

- Do not regularly exercise, but have an active lifestyle
- Have difficulty accomplishing light chores of daily living
- Require assistance to accomplish self-care

Have You Ever Had Any of the Following	Yes	No	Date or Year	Place (Hospital or City)	Complications/Problems
Exam by a Cardiologist (Heart Doctor)	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Catheterization or Angiogram	<input type="checkbox"/>	<input type="checkbox"/>			
Coronary Angioplasty (PTCA/Balloon/Stents)	<input type="checkbox"/>	<input type="checkbox"/>			
Exercise Stress Test (Treadmill)	<input type="checkbox"/>	<input type="checkbox"/>			
Echocardiogram (Ultrasound of the Heart)	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>			
Open Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Nuclear Study	<input type="checkbox"/>	<input type="checkbox"/>			
Holter/Event	<input type="checkbox"/>	<input type="checkbox"/>			

Previous Operations/Procedures	Year	Surgeon	Place (Hospital or City)	Complications/Problems

Reasons for other Hospitalizations (non-Surgical Admissions)	Year	Physician	Complications/Problems

Please List Any Other Medical Illnesses, Any Other History of Cancer or Chronic Conditions	How Long Have You Had This

Family History

- Heart Attack
- Sudden Death
- Stroke
- Aneurysm
- Diabetes
- Cancer
- High Blood Pressure
- High Cholesterol
- Heart Failure

Relation	Age	Age at Death	Heart Attack	Sudden Death	Stroke	Aneurysm	Diabetes	Cancer	High Blood Pressure	High Cholesterol	Heart Failure
Father:											
Mother:											
Sister:											
Sister:											
Brother:											
Brother:											

Name of Patient: _____
Last First M.I.

DOB: _____

Review of Systems

EYES

- Permanent blindness in either eye
- Cataracts
- Glaucoma
- Vision changes

HEART

- Heart attack, What year (s): _____
- Chest discomfort/angina with physical activity
- Chest discomfort/angina at rest
- Shortness of breath with exertion
- Shortness of breath at rest
- Require more than one pillow at night to breathe well
- Heart failure or "fluid on lungs"
- Palpitations, racing or pounding heart beat
- Pauses in the heart beat
- Previously diagnosed heart rhythm disturbance
- Heart murmur
- Mitral valve prolapse

BLOOD

- Bleeding or bruising tendency
- Frequent or severe nose bleeds
- Blood disorder
- Specify: _____
- Previous blood transfusion
- Recent fever
- History of hepatitis or other communicable disease

STOMACH/INTESTINES

- Stomach ulcer or peptic ulcer
- Dark, tarry stools

NERVOUS SYSTEM

- Frequent headaches or migraines
- Epilepsy or seizures
- Depression
- Nervous disorder
- Memory loss

CIRCULATION

- Discoloration of feet or legs
- Pain in legs or buttocks with exercise
- Non-healing sores or ulcers on feet or legs
- Blood clot in artery
- Blood clot in leg vein
- Ankle or leg swelling
- Phlebitis of leg veins
- Sudden visual disturbances in either eye
- Weakness or paralysis of one side of the body
- Temporary speech loss or difficulty talking
- Stroke
- Dizziness, light-headedness or "black out spells"
- Aneurysm of any blood vessels
- "Mini-strokes" or TIA's

LUNGS

- Asthma or wheezing
- Pneumonia
- Emphysema
- Chronic cough
- Coughing up blood

KIDNEY/URINARY TRACT

- Kidney disease or failure
- History of Kidney dialysis
What year: _____
- Kidney stones or infection
- Blood in urine during past year

METABOLISM/ENDOCRINE

- Thyroid disorder
- Gout
- Recent weight gain or loss (> 10 lbs)

MUSCLES/BONES/JOINTS

- Arthritis or other joint disease

REPRODUCTIVE (for women)

Are you or might you be pregnant?

- Yes No

Date (or year) of last period: _____

REPRODUCTIVE (for men)

Erectile Dysfunction?

- Yes No