



**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 Monitor	<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 Medical Illnesses or Chronic Conditions Not Listed	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.

Date of Birth: \_\_\_\_\_

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### Review of Symptoms

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#### 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





