

Appt Date: _____
Location: _____

Form 4, Patient Information Form
Tri-City Cardiology Consultants, P.C.

Date: _____ Patient Name: _____ DOB: _____
Height: _____ Weight: _____ Sex: _____ Age: _____
Primary Care Physician: _____
Are there any other Physicians involved in your care? _____
Reason for visit: _____
Have you seen a physician for this in the past? _____
If so, what treatment was given? _____

Have you ever had or are you currently experiencing any of the following?

	Yes	No		Yes	No
Myocardial Infarction (heart attack)	<input type="checkbox"/>	<input type="checkbox"/>	Syncope (passing out)	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Vascular Accident (stroke)	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal EKG / Stress	<input type="checkbox"/>	<input type="checkbox"/>	TIA (mini stroke)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
PVC's	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever had any of the following problems?

	Yes	No		Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Passing Out	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>			
Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			

Do you have any other illnesses not listed above? _____

Specify: _____

Have you ever had any of the following heart tests performed?

	Yes No	
Echo	<input type="checkbox"/> <input type="checkbox"/>	If so, when/where _____
Stress Test	<input type="checkbox"/> <input type="checkbox"/>	If so, when/where _____
Nuclear Study	<input type="checkbox"/> <input type="checkbox"/>	If so, when/where _____
Holter/Event Monitor	<input type="checkbox"/> <input type="checkbox"/>	If so, when/where _____

Have you recently been hospitalized? If yes, please list details:

Date	Name of Hospital	Diagnosis

Family History:

	Living?	Age	Major Illnesses	Cause of Death
	Yes No			
Father	<input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____
Mother	<input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____
_____	<input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____
_____	<input type="checkbox"/> <input type="checkbox"/>	_____	_____	_____

General Questions:

Are you on a special diet? _____

Do you smoke cigarettes? _____ How many packs per day? _____

Do you drink alcohol? _____ yes _____ no

How many servings per week? _____ (beer) _____ (wine) _____ (liquor)

Do you drink caffeine? _____ yes _____ no

How many servings per day? _____ (coffee) _____ (tea) _____ (soda) _____ (other)

Any other drug use? _____

What medications are you taking? Please list below:

Drug	Dose/Strength	Frequency

Are you allergic to any drugs? _____ yes _____ no Please list the drug and the reaction:

Pharmacy Name: _____ Address: _____ Phone Number: _____