PATIENT INFORMATION FORM
Tri-City Cardiology

☐ Baywood ☐ Dobson ☐ Gilbert ☐ San Tan Valley ☐ Scottsdale ☐ Vein Center

Patient Name: _____ Date of Visit:_____ _____
First Last M.I.

Date of Birth: _____ Age:_____ Sex:_____ Height:_____ Weight:_____lbs.

Referring Doctor:_____ Primary Care Doctor:_____

Reason for Visit (current symptoms today):_____

Recent hospitalization? If yes, please explain:_____

_____

Drug/Food Allergies

Are you allergic to any medications: ☐ Yes ☐ No

Medications you are allergic to: Reaction:

_____ _____

_____ _____

_____ _____

Other allergies (food, adhesive tape, iodine, latex, etc.): _____

_____

Current Medications (please list all prescription, non-prescription, vitamins and nutritional supplements)

CURRENT MEDICATIONS	DOSE (Strength)	DOSAGE (How many & times per day)	DO YOU NEED ANY REFILLS?
Example: Lopressor	*50 mg*	*1 tablet, two times a day*	30 Days or 90 Days
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90

Local Pharmacy (name & crossroads):_____ Phone: ( )_____-_____

Mail Order Pharmacy:_____ Fax: ( )_____-_____

Risk Factors

Do You Use Tobacco: ☐ Current ☐ Former ☐ Never **If former, Year Quit:**_____

If Yes, Type: ☐ Chewing ☐ Cigarettes ☐ Pipe ☐ Smokeless

Packs/day_____ Years used_____ Passive smoke exposure: ☐ No ☐ Yes

Have you ever been diagnosed or are taking medications for the following conditions:

Diabetes: ☐ Yes ☐ No ☐ Unknown **If Yes, Type:** ☐ Type 1 (Juvenile) ☐ Type 2 (Adult onset) **Year diagnosed**_____

High Cholesterol: ☐ Yes ☐ No ☐ Unknown

If Yes, Type: ☐ Cholesterol ☐ Triglycerides ☐ Cholesterol+Triglycerides ☐ Low HDL Syndrome

High Blood Pressure: ☐ Yes ☐ No ☐ Unknown **Year diagnosed**_____

Family History of Heart Disease(CAD) prior to age 55: ☐ Yes ☐ No ☐ Unknown ☐ Adopted (No Fam Hx Unknown)

Peripheral Vascular Disease (poor circulation in legs): ☐ Yes ☐ No ☐ Unknown

Social History

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed ☐ Life Partner ☐ Other:_____

Do you have children: ☐ No ☐ Yes **If Yes**, Number of sons:_____ Number of daughters:_____

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Asian
Pacific Islander/Native Hawaiian Other ☐ _____ ☐ Declined

Do you follow a specific Diet: *(check all that apply)*

☐ Diabetic ☐ Low Carb ☐ Low Fat, Low Chol ☐ Low Salt ☐ No Added Salt ☐ No specific diet

☐ Regular ☐ Renal ☐ Vegetarian ☐ Weight loss ☐ Other:_____

Activity Level (exercise): ☐ Sedentary ☐ Occasional ☐ Regular ☐ Active Life Style ☐ Physically Unable to Exercise

Exercise Type: *(check all that apply)* **Frequency:**_____*(times per week)*

☐ Aerobics ☐ Cycling ☐ Dancing ☐ Elliptical ☐ Jogging ☐ Physical Therapy ☐ Running ☐ Swimming

☐ Team Sports ☐ Walking ☐ Weight lifting ☐ Other:_____

Do you consume Alcohol: ☐ Yes ☐ No ☐ Former **If Yes, What Type:** ☐ Beer ☐ Wine ☐ Liquor

If Yes, Frequency: ☐ Rarely ☐ Frequently ☐ Social ☐ Occasional ☐ Daily **Drinks per week:**_____

Do you consume Caffeine on a daily basis: ☐ Yes ☐ No **Cups per day:**_____

If Yes, What type: ☐ Chocolate ☐ Coffee ☐ Energy Drink ☐ Soda ☐ Tablets ☐ Tea
Other:_____

Drug use/Abuse: ☐ Yes ☐ No ☐ Former **If Yes, What type:**_____

Advanced Directives: ☐ None ☐ DNR ☐ HC Proxy ☐ Living Will

Primary Language: ☐ English ☐ Spanish ☐ Other:_____

Family History

☐ **Unknown-** ***(Unknown)Family Hx***
☐ **Adopted -** ***(Unknown)Family Hx***

Place a check mark in the box for any conditions below that apply:

RELATIONSHIP TO PATIENT:	MOTHER	FATHER	SISTER	SISTER	BROTHER	BROTHER	OTHER: _____
CURRENT AGE:							
AGE AT DEATH:							
HEART ATTACK:							
ARRHYTHMIA:							
HEART FAILURE:							
ANEURYSM:							
STROKE(CVA):							
HIGH BLOOD PRESSURE:							
HIGH CHOLESTEROL:							
DIABETES:							
LUNG DISEASE:							
RENAL DISEASE:							
CANCER: Type:_____							

Other pertinent family history:

_____

_____

Past Medical History

Place a check mark in the box for any of the conditions that apply:

Respiratory: ☐ COPD ☐ Pulmonary Embolus ☐ Pulmonary Hypertension ☐ Sleep Apnea ☐ Other:_____

Renal: ☐ End Stage Renal Disease Renal Artery Stenosis ☐ Renal Insufficiency ☐ Other:_____

Endocrine: ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Obesity ☐ Other:_____

Oncology: ☐ Breast Cancer ☐ Skin Cancer ☐ Lung Cancer ☐ Prostate Cancer ☐ Other:_____

☐ Chemotherapy ☐ Radiation ☐ Other:_____

Cardiac: ☐ Arrhythmias ☐ Congestive Heart Failure ☐ CAD ☐ Heart Attack (MI) ☐ Valvular Heart Disease

☐ CABG (Bypass) ☐ Coronary Stent ☐ ICD ☐ Pacemaker ☐ PTCA (Angioplasty)
Other:_____

Vascular: ☐ Abdominal Aneurysm ☐ Peripheral Arterial Disease ☐ Carotid Disease ☐ DVT ☐ Thoracic Aneurysm

☐ Varicose Veins ☐ Amputation ☐ Aneurysm Repair ☐ Vein Stripping ☐ Other:_____

List any other medical conditions:

_____

_____

List any other surgeries:

_____

_____

Cardiac Testing	Yes No	Date or Year	Location or Hospital	Additional Comments
Echo (ultrasound):	☐ ☐			
Electrophysiology:	☐ ☐			
Cath Lab:	☐ ☐			
Vascular:	☐ ☐			
Stress Test:	☐ ☐			
CT/MRI:	☐ ☐			
Other: _____	☐ ☐			

Any other cardiac testing:_____

_____

Review of Symptoms

Check only the problems you are currently experiencing:

	Y	N		Y	N	
Cardiac:	○	○	Chest Pain (pressure)	○	○	Diaphoresis (excessive perspiration)
	○	○	Palpitation (fluttering)	○	○	Syncope (loss of conciousness)
	○	○	Orthopnea (trouble breathing lying down)	○	○	PND (trouble breathing at night)
Vascular:	○	○	Claudication (leg pain)	○	○	Edema (swelling)
Constitutional:	○	○	Weight Gain	○	○	Weight Loss
	○	○	Fever			
HEENT:	○	○	Visual Changes	○	○	Hearing Loss
Respiratory:	○	○	Snoring	○	○	Hemoptysis (coughing up blood)
	○	○	Dyspnea (shortness of breath)			
Gastrointestinal:	○	○	Nausea	○	○	Reflux
	○	○	Bleeding			
Genitourinary:	○	○	Hematuria (blood in urine)	○	○	Nocturia (nighttime urination)
Neurology:	○	○	Dizziness	○	○	Memory Loss
	○	○	Seizures			
Psychiatric:	○	○	Depression	○	○	Hallucinations
Hematologic:	○	○	Acute Anemia	○	○	Thrombocytopenia (low platelet count)
Endocrine:	○	○	Goiter (enlarged thyroid)	○	○	Tremors
Derm(Skin):	○	○	Rash	○	○	Skin Sores
Musculoskeletal:	○	○	Joint Pain	○	○	Myalgia (muscle pain)

Any additional symptoms you are experiencing:

_____

_____

_____

Patient Name (printed): _____ **Date:** _____