Pham Cardiovascular Center

NAME: _____ Date of Birth: ____/____/_____

HPI/Symptoms: Please check & describe any of the following symptoms which you have.

Chest pain/tightness/pressure/discomfort? ____ Approximately when did this begin? _____ How would you describe it (sharp, dull, ache, etc.:) _____

Does it radiate to other areas of your body? _____ If yes, where? _____ In what situations do you usually get the discomfort? Resting Anxiety/tension Sleep Exercise Other _____ How long does it usually last? _____ What helps it go away faster? _____

Shortness of breath? _____ Approximately when did this begin? _____ In what situations do you usually get this symptom? Resting Anxiety/tension Lying down Exercise Other How long does it usually last? _____ What helps it go away faster? _____

Palpitations/fast heart rate? _____ Approximately when did this begin? _____ In what situations do you usually get this symptom? Resting Anxiety/tension During Sleep Exercise Other _____ How long does it usually last? _____

Dizziness? _____ Approximately when did this begin? _____ In what situations do you usually get this symptom? Resting Anxiety/tension During Sleep Exercise Other _____ How long does it usually last? _____ Have you ever lost consciousness during one of these spells? _____

Pain in the calves of the legs/hips _____ Approximately when did this begin? _____ In what situations do you usually get this symptom? Resting During Exercise Other: _____ How long does it usually last? _____ Swelling of the feet/ankles/etc. _____

MEDICATION LIST, including vitamins and supplements (continue on back of page if more space is needed):

Name	Dose	How often

DRUG ALLERGIES / ADVERSE REACTION (what happens when you take it?):

(FOR OFFICE USE ONLY) **FOLLOWUP**

HR	BP	WEIGHT	HEIGHT	O2%

PAST MEDICAL HISTORY

*** Hospitalizations**

Hospital & City	Reason	Doctor	Year

***Surgeries**

Hospital & City	Reason	Doctor	Year

CARDIOVASCULAR HISTORY:

***** Do you have a history of any of the following?

Diabetes _____ Hypertension_____ High cholesterol _____ Angina _____

Heart Failure _____ Heart murmur _____ Rheumatic fever _____ Valve disease _____

Coronary Artery Disease _____ Heart Attack _____

***** Have you had any of the following tests? ***If yes, explain when, where, & results if known.***

Treadmill test _____

Heart monitor _____

Heart echo (ultrasound) _____

Nuclear heart scan_____

Heart catheterization/angiogram _____

Pacemaker/Defibrillator (type) _____

Stent _____

FAMILY HISTORY (use back of page if additional space is needed)

Any **family** history of the following?

If yes**, which family member, maternal or paternal side?**

___ Heart attack _____

___ Heart failure _____

___ Diabetes _____

___ High cholesterol _____

___ Stroke _____

SOCIAL HISTORY

Do you **exercise**? ____ How many times weekly? _____ Amount daily of **caffeine**: _____

Do you drink **alcohol**? _____ How much and how often? _____

Do you use **recreational drugs**? _____ Do you **smoke**? ____ How much? _____

If you do not smoke now, did you ever? ____ How many years since you've quit? _____

REVIEW OF SYSTEMS:

Please check if you are experiencing any of these symptoms:

General: ___ weakness ___ weight change ___ fatigue

Eyes: ___ glasses ___ blind spots ___ inflammation ___ double vision

Ears: ___ deafness ___ ringing in ears ___ vertigo

Respiratory: ___ cough ___ sputum production ___ wheezing ___ coughing up blood

Endocrine: ___ thyroid disorder ___ goiter ___ feel hot or cold when others are not affected

Gastro-Intestinal: ___ tooth or gum disease ___ belching ___ heart burn ___ abdominal pain ___ constipation

Musculoskeletal: ___ limitation of movement of joints ___ swelling of joints

Neurological: ___ frequent headaches ___ partial/temporary loss of vision ___ severe headaches

___ numbness/tingling of face ___ partial/temporary loss of speech ___ weakness of arms/legs

Skin: ___ easy bruising

Genito-Urinary: ___ difficulty urinating ___ painful urination ___ kidney stones