Patient Name: _____ DOB _____ Date _____

Reason for this visit: _____

Referring Physician: _____

Have you had any of the following? Please check the appropriate box below:

	Yes	No	
Diabetes	☐	☐	
Hypertension	☐	☐	
Cancer	☐	☐	
Bleeding Disorder	☐	☐	
High Cholesterol	☐	☐	
Stroke	☐	☐	
Chest Pain	☐	☐	
Shortness of Breath	☐	☐	
Family History of Disease	☐	☐	
Palpitations	☐	☐	
Irregular Heart Beat	☐	☐	
Surgeries (if yes explain)	☐	☐	_____

Additional problems _____

Check appropriate box. If yes please provide further information.

	Yes	No	
Allergies (food/drug)	☐	☐	_____
Smoker (Prior/Present)	☐	☐	_____
Drink Alcohol	☐	☐	_____
Use Illicit Drugs	☐	☐	_____

Name: _____

Medications, strength, frequency, date started:

_____

_____

_____

_____

Vaccine **date:**

- ☐ Flu _____
- ☐ Pneumonia _____

Cardiac Testing:

Have you had the following? If yes provide year and result.

	Yes	No	Year	Positive	Negative
Exercise Stress Test	☐	☐	_____	☐	☐
Nuclear Stress Test	☐	☐	_____	☐	☐
Echocardiogram	☐	☐	_____	☐	☐
Stress Echocardiogram	☐	☐	_____	☐	☐
Carotid Ultrasound	☐	☐	_____	☐	☐
Ankle Brachial Indexing	☐	☐	_____	☐	☐
Holter Monitor	☐	☐	_____	☐	☐
24 Hour BP Monitor	☐	☐	_____	☐	☐