METROPOLITAN CARDIOLOGY CONSULTANTS

PATIENT NAME	DATE OF BIRTH	DATE OF EVALUATION

Please answer yes to any items which apply; the doctor will discuss these answers with you in greater detail.

DO YOU HAVE ANY HISTORY OF:

Risk Factors for Coronary Disease

- Hypertension (high blood pressure) ..... Yes ☐ No ☐
- Diabetes ..... Yes ☐ No ☐
- High cholesterol ..... Yes ☐ No ☐
- Current cigarette smoking ..... Yes ☐ No ☐
- Prior tobacco smoking ..... Yes ☐ No ☐
- History in parents, siblings, grandparents of heart disease, heart attack, heart bypass surgery ..... Yes ☐ No ☐

Cardiac History

- History of heart murmur ..... Yes ☐ No ☐
- History of rheumatic fever ..... Yes ☐ No ☐
- Fainting spell, passing out ..... Yes ☐ No ☐
- Unusual breathlessness with activity ..... Yes ☐ No ☐
- Chest discomfort with activity ..... Yes ☐ No ☐
- Diagnosis of angina, heart attack, or heart failure ..... Yes ☐ No ☐
- Need to sleep upright or on many pillows to breathe comfortably ..... Yes ☐ No ☐
- Swelling of the ankles or feet (edema) ..... Yes ☐ No ☐
- Unusual, strong, or frequent palpitations ..... Yes ☐ No ☐
- Calf and thigh cramps / tightening with walking hills ..... Yes ☐ No ☐
- Prior hospitalization for any cardiac concern or problem ..... Yes ☐ No ☐
- Prior cardiac evaluation with echocardiogram, stress test, thallium stress test or angiogram (catheterization) ..... Yes ☐ No ☐

MEDICATIONS *(please specify)*: _____

_____

_____

_____

Prior Medical History

- Asthma, emphysema, wheezing, bronchitis, or frequent sputum production ..... Yes ☐ No ☐
- Ulcers, intestinal bleeding ..... Yes ☐ No ☐
- Blood in stool ..... Yes ☐ No ☐
- Gastrointesthal problems ..... Yes ☐ No ☐
- Liver disease ..... Yes ☐ No ☐
- Urinary, bladder, or prostate problems ..... Yes ☐ No ☐
- Anemia, low blood count, iron deficiency ..... Yes ☐ No ☐
- Stroke or mini stroke (TIA), neurological problems ..... Yes ☐ No ☐
- Kidney disease, kidney stones ..... Yes ☐ No ☐
- Thyroid disease or any gland problem ..... Yes ☐ No ☐
- Phlebitis, blood clots, prior treatment with anticoagulant (Blood thinning medication) ..... Yes ☐ No ☐
- Any serious or chronic infectious disease ..... Yes ☐ No ☐

Alcohol Consumption: _____

Caffeine Consumption: _____

Prior Major Surgery *(please specify)*: _____

_____

_____

_____

Other Non-Surgical Hospitalizations: _____

_____

_____

_____

Allergy To Medications *(please specify)*: _____

_____

_____

Other Physicians Caring For Patient: _____

_____