MIS © Adult Cardiology Information

Patient Name: _____ Chart # / Office: _____

Home Phone: _____ Referring Physician: _____

Work Phone: _____ Date: _____

PLEASE ANSWER *ALL* QUESTIONS:

What is your reason for today's visit? _____

1. When did this problem / discomfort start? _____
2. Where is the problem / discomfort located? _____
3. What makes this problem / discomfort worse? _____
4. If there any other symptoms associated with this problem / discomfort, please describe: _____

_____

_____

General Review of Systems: Are you currently having any of the following ?

Y N Fevers? Y N Constipation? Y N Chest Discomfort? Y N Back Ache?
Y N Headache? Y N Blurred Vision? Y N Skin Rashes? Y N Shortness of Breath?
Y N Depression? Y N Non Healing Sores? Y N Bleeding Tendencies?

Are you currently taking any medications ? If yes, please list: _____

_____

_____

_____

Please list any allergies to medications:

_____

_____

Past Medical / Family / Social History: (Check all that apply and provide information below)

Do you have a history of _____High blood pressure ____Heart Disease ____Heart Valve problems ____Diabetes
____Liver Disease ____Kidney Disease ____Cancer ____Lung problems ____Stroke ____HIV exposure
Do you: ____Smoke ____Drink Alcohol ____Use Drugs ____Take Aspirin Products
Has anyone in your family had: ____Cancer ____Heart Problems ____Kidney Disease ____Diabetes

_____

_____

_____

Please list your: (Give approximate dates for surgeries / hospitalizations)

Major Medical Problems	**Past Surgeries / Hospitalizations / Dates**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please See Reverse Side

Patient Chart # _____

Cardiology Review: Are you currently having, or have history of, any of the following?

Y N Chest pain ? Number of times / day ___
Location. Front of chest / Left shoulder / left arm abdomen
How long does it last? Minutes / hours / days
Does anything relieve the pain? _____

Y N Do you have palpitations, dizziness or feeling of rapid irregular heart beating?

Y N Have you passed out?

Y N Do you have shortness of breath ?
How far can you walk before stopping? Across room / 100 feet / 1 block / longer

Y N Do you have pains in your legs with walking?
Where is the pain located? legs / thighs / buttocks

Y N Does the pain stop at rest?

Y N Does the pain wake you at night?

Y N Do you have any non healing sores on your legs?

Y N (Men) Do you have any erection problems?

Y N Have you had a Flu Shot? If so, when last given. _____

Y N Have you had a Pneumovax Shot? If so, when last given: _____

_____

_____

_____

_____

I understand that I am responsible for calling Eastlake Cardiovascular at (586) 498-0440, for my test results, one week after I have any testing done.

I understand that payment is due at the time of my office visit.

Patient signature: _____

Physician signature: _____