

Cardiac Risk Factors

History of tobacco use? **Yes** **No**
Family history of heart disease? **Yes** **No**
History high cholesterol? **Yes** **No**
Do you have high blood pressure? **Yes** **No**
History of diabetes mellitus? **Yes** **No** / If yes, are you on Insulin? **Yes** **No**
Have you been diagnosed with heart disease? **Yes** **No**
History of obesity? **Yes** **No**
Do you live a sedentary (non-active) lifestyle? **Yes** **No**
How old are you? _____
If female, are you menopausal? **Yes** **No** / If yes, are you on any hormone supplements? **Yes** **No**

Past Medical History

Do you, or **have** you had any of the following? (Please circle all that apply)

General Health Profile

Abdominal aortic aneurysm
Anxiety
Anemia
Arthritis (generalized)
Arthritis (osteoarthritis)
Arthritis (rheumatoid)
BPH-prostate enlargement
Cancer: Yes No Type: _____
Carotid artery blockage
 -Right
 -Bilaterally
Colitis
COPD
Crohn's Disease
Depression
Diabetes
 -Insulin dependent
 -Non-insulin dependent

Emphysema
Erectile Dysfunction
Gastric Ulcer
GERD/Reflux
Fibromyalgia
Hiatal hernia
Hypothyroidism
Hyperthyroidism
Hypercholesterolemia (high cholesterol)
Hypertension
Hemorrhoids
Kidney stones
Kidney insufficiency
Lyme Disease
Lupus

Macular degeneration
Peripheral Vascular Disease
Panic Attacks
Parkinson's Disease
Polymyalgia
Pulmonary Hypertension
Pulmonary Embolism
Renal Failure
Sleep Apnea
Syncope

Cardiac Health Profile

Angina
Aortic stenosis
Aortic insufficiency
Aortic regurgitation
Atrial flutter
Atrial fibrillation
Bradycardia (slow heart rate)
Cardiomyopathy
Chest pain
Congestive heart failure
Coronary heart disease
Heart attack/MI
Irregular heart beat
Mitral valve: Prolapse, Regurgitation, Stenosis
Palpitations
Pericarditis
Pulmonary valve stenosis
Tachycardia (fast heart rate)
Tricuspid valve: Regurgitation, Stenosis
Wolf Parkinson's White

Please list any other illnesses you have or have had, as well as any broken bones or major burns?

Past Medical History cont.

Do you, or **have** you had any of the following? (Please circle all that apply)

Infectious Disease History

Chicken Pox Measles/Mumps Polio Malaria Tuberculosis HIV/AIDS

Rheumatic/Scarlet Fever Meningitis: Viral/Bacterial Hepatitis: A, B, C

Surgery/Procedure History

Aneurysm repair of the abdomen

Appendectomy

Breast Biopsy

Breast Lumpectomy

Breast removal for cancer (mastectomy)

Breast enlargement

Heart Valve Surgery

 Aortic valve replaced

 Mitral valve replaced

Heart Bypass Surgery

 How Many: _____

 When: _____

 Where: _____

Cataract Removal

 Right eye Left eye Both eyes

 (Did you have lens implants? Yes / No)

Gallbladder Removed

PTCA (balloon angioplasty)

 How Many: _____

 When: _____

 Where: _____

Stent (wire coil) placed in heart artery

 How Many: _____

 When: _____

 Where: _____

Carotid artery surgery (neck)

 Right Left Both

Hemorrhoid surgery

Hip replacement

 Right Left Both

Knee Replacement

 Right Left Both

Lung surgery

Thyroid gland removed

Prostate removed

Prostate "reamed out"

Varicose veins stripped

 Right leg Left leg Both legs

Heart Catheterizations

How Many: _____

When: _____

Where: _____

Who: _____

Hysterectomy:

 Total Partial (Still Have Ovaries)

Shoulder Surgery

 Right Left Both

Tonsillectomy Adenoidectomy

Carpal tunnel surgery

 Right Left Both

Any other surgical procedures, please list:

Trauma History

Have you had any history of trauma? Yes / No

If so, please explain: _____

Cardiac Procedures (Invasive)

Angiogram/Heart Cath

Cardioversion

Stents

Ablation

Heart Transplant

Myocardial Biopsy

Pacemaker Implant

Bypass Surgery

Other: _____

Review of Symptoms

Have you had any of the following problems or symptoms recently? (Please circle all that apply)

General:

Feels well, Fatigue, Weight Loss, Weight Gain, Appetite Loss, Appetite Gain

Integumentary:

Hair Loss, Dry Skin, Rash, Skin Cancer, Mole Change, Nail/Skin/Hair Changes

Eyes:

Vision 20/20, Glasses/Contacts, Glasses (Reading Only), Legally Blind, Discharge, Pain Glaucoma, Blurred Vision, Macular Degeneration, Double Vision, Color Blindness

Ears, Nose, Mouth, Throat:

Hearing Loss: Partial or Complete, Hearing Aids, Vertigo, Hoarseness, Difficulty Speaking, Sinusitis

Respiratory:

History of Asthma, COPD, Emphysema, Dyspnea (Short of Breath): At Rest or With Exertion, Cough: Dry or Productive, Frequent Napping, Sleep Apnea, Snoring, Wheezing

Cardiovascular:

Chest Pain, Palpitations, Edema (swelling) - Where do you swell?: _____

Gastrointestinal:

Abdominal Pain, Constipation, Diarrhea, Nausea, Change in Bowel Habits

Genitourinary General:

Dysuria (Painful Urination), Frequency, Hematuria (Blood in Urine), Nocturia, Urgency, Chronic UTI

Female Genitourinary: Regular Periods, Heavy Menstrual Flow, Hot Flashes, Menopausal: Natural or Surgical

Male Genitourinary: History of BPH, Prostate Cancer, Impotence, Decrease Libido

Musculoskeletal:

Arthritis of the: _____, Muscle Pain or Cramps, Loss of Strength, Back Pain, Gout

Neurological:

Confusion, Dementia, Dizziness, Headaches, Memory Loss, TIA, Numbness - Where?: _____

Psychiatric:

Anxiety, Change in Behavior, Depression, Stress, Sleep Disturbance, Thoughts of Suicide

Endocrine:

Fatigue, Hyperlipidemia, Hypothyroidism, Hyperthyroidism, Diabetes: Non-Insulin Dependent or Insulin Dependent, Intolerance to Heat, Intolerance to Cold

Hematological/Immunologic:

Bleeding Disorders, Easy Bruising, Vit B-12 Deficiency, Seasonal Allergies, Medical Allergies, Food Allergies

Symptoms: Are you having any of the following symptoms?

Cramping in hip, thigh, or calf	Yes	No
Leg numbness or weakness	Yes	No
Coldness in your feet	Yes	No
Sores on your toes, feet, or legs that won't heal	Yes	No
No pulse or a weak pulse in your legs or feet	Yes	No
Erectile dysfunction in men.	Yes	No

