South Denver Cardiology Associates

Today's Date: _____

PATIENT INFORMATION DATA (please print) Social Security (Last four #): _____

Name: _____ Date of Birth: _____ Gender (circle one) F M

Address: _____ City: _____ Zip Code: _____

Home phone #: _____ Work phone #: _____ E-mail: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/other Pacific Island ☐ Other ☐ Declined **(Select one)**

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined **(Select one)**

Reason for today's visit: _____

Referring physician and all physicians to send report of visit: _____

Local Pharmacy _____ Phone# _____ Mail Order Pharmacy Company _____

PAST MEDICAL AND SURGICAL HISTORY (Please circle and explain)

Heart attacks, angioplasties, angina: _____

Heart Valve disease _____ Heart rhythm abnormalities

Congestive Heart Failure _____ Heart surgery _____

Smoke ever? YES / NO Packs per day _____ Years smoking _____ Currently, smoke? YES / NO Year quit _____

Diabetes? YES / NO Duration _____ High blood pressure? YES / NO

High Cholesterol? YES / NO

Asthma or emphysema Rheumatic Fever Strokes/TIAs

Other significant illnesses _____

Surgeries _____

Most recent blood work: Where _____ When _____

SOCIAL HISTORY Occupation: _____

Marital Status (circle) Single Married Divorced Widowed Separated

Alcoholic drinks (average per week) _____ Recreational drug use? YES / NO Caffeinated drinks a day _____

ALLERGIES

Medication allergies _____

Have you ever had an X-ray dye? YES / NO Any reaction to x-ray dye, iodine, or shellfish? _____

PATIENT INFORMATION: Name: _____ Date of Birth: _____

Family History (Example: Mother- Hypertension)

Please list parents, children, grandparents, aunts and uncles with the following illnesses: Heart Disease, strokes, diabetes, high blood pressure

_____

_____

MEDICATIONS (Include over the counter medications and herbal supplements)

MEDICATIONS	DOSAGE AND FREQUENCY	REASON FOR TAKING

SYMPTOM REVIEW (please circle if you are having any of the following)

Fevers Chills Weight Gain / Weight Loss Visual changes Nosebleeds Hoarseness Hearing problems Chest pain/pressure/heaviness Irregular pulse/palpitations Edema/swelling Shortness of breath at rest Cough Shortness of breath with exercise Shortness of breath when lying flat Wheezing Abdominal pain Vomiting Blood in stool/black stool Painful urination Muscle Aches Muscle Weakness Skin Changes Dizziness Fainting/near fainting Anxiety Depression Easy bleeding Easy Bruising Erectile Dysfunction

SLEEP HABITS: Do you snore? YES / NO Are you excessively tired during the day? YES / NO

Have you been told you stop breathing during sleep? YES / NO Is your neck size >17" (male) and >16" (female)? YES / NO

REGARDING LEG PAIN OR CRAMPS:

Do you get pain or discomfort in your leg(s) when you walk? YES / NO **IF YES**, please complete the leg pain form and answer the appropriate questions. **If NO**, please disregard.

Name: _____ **Date of Birth:** _____

Leg Pain and Cramps Questionnaire

1) Do you get pain or discomfort in your leg(s) when you walk?

   Yes / No I am unable to walk

*If you answered **"Yes"** to question (1) - please answer the, following questions. Otherwise, you need not continue.

2) Does this pain ever begin when you are standing still or sitting? Yes / No

3) Do you get it if you walk uphill or hurry? Yes / No

4) Do you get it when you walk at an ordinary pace on the level? Yes / No

5) What happens to it if you stand still?

   Usually continues more than 10 minutes

   Usually disappears in 10 minutes or less

6) Where do you get this pain or discomfort? Mark the place(s) with "x" on the diagram below.

Please check all that apply.