

# Cardiology Patient Intake Form

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

## PLEASE ANSWER ALL QUESTIONS

### What is your reason for today's visit?

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

## GENERAL REVIEW OF SYSTEMS Are you currently having any of the following symptoms? (Please circle yes or no)

### Constitutional:

- Y N Recent weight change
- Y N Fever
- Y N Chills
- Y N Fatigue

### Eyes:

- Y N Blurred/impaired vision

### ENT:

- Y N Hearing loss
- Y N Ringing in ears
- Y N Nose bleeds
- Y N Bleeding gums
- Y N Sore throat or voice change
- Y N Swollen glands in neck

### Cardiovascular:

- Y N Chest pains/discomfort
- Y N Sudden heart beat changes
- Y N Palpitations/racing heart beat
- Y N Swelling of feet, ankles or hands

### Respiratory:

- Y N Frequent coughing
- Y N Sputum productive cough
- Y N Spitting up blood
- Y N Shortness of breath
- Y N Asthma or wheezing

### Gastrointestinal:

- Y N Loss of appetite
- Y N Change in bowel movements
- Y N Nausea
- Y N Vomiting
- Y N Frequent diarrhea
- Y N Painful bowel movements/constipation
- Y N Blood in stool
- Y N Stomach pain
- Y N Heartburn
- Y N Reflux

### Genitourinary:

- Y N Frequent urination
- Y N Burning or painful urination
- Y N Blood in urine
- Y N Incontinence or dribbling
- Y N Kidney stones
- Y N Sexual difficulty
- Y N Erection Problems

### Musculoskeletal:

- Y N Joint pain
- Y N Joint stiffness or swelling
- Y N Weakness of muscles/joints
- Y N Muscle pain or cramps
- Y N Back pain
- Y N Cold extremities
- Y N Leg pain with walking
- Y N Leg swelling
- Y N Limb weakness

### Skin:

- Y N Rash
- Y N Itching skin
- Y N Change in skin color
- Y N Varicose veins
- Y N Easily bruise
- Y N Non-healing sores

### Psychiatric:

- Y N Memory loss or confusion
- Y N Nervousness
- Y N Depression
- Y N Sleep problems
- Y N Suicidal thoughts

### Neurological:

- Y N Syncope/Passing out
- Y N Near Syncope
- Y N Headaches
- Y N Lightheaded
- Y N Dizziness
- Y N Convulsions or seizures
- Y N Numbness or tingling
- Y N Tremors
- Y N Paralysis
- Y N Stroke
- Y N Head injury
- Y N Slurred speech

### Endocrine:

- Y N Thyroid disease
- Y N Diabetes
- Y N Excessive thirst
- Y N Excessive urination
- Y N Heat or cold intolerance
- Y N Dry skin

### Hematologic/Lymphatic:

- Y N Slow to heal after cuts
- Y N Bleeding tendencies
- Y N Anemia

### Adverse Reactions to:

- Y N Penicillin or antibiotics
- Y N Morphine, Demerol, narcotics
- Y N Novocain, other anesthetics
- Y N Aspirin or other pain remedies
- Y N Tetanus antitoxin, other serum
- Y N Iodine, methiolate, antiseptics

List all allergies that you have: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**Thank you for completing all questions**

**Please list all PRESCRIPTION medications that you take**

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List all OVER THE COUNTER medications that you take**

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Past Medical History: (Check all that apply)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Previous Heart Attach | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Heart Valve Problems    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> COPD            | <input type="checkbox"/> Bleeding Disorder     |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HIV Disease/exposure  |
| <input type="checkbox"/> Heart Failure           | <input type="checkbox"/> Blood Clot in Legs    | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Hepatitis (A, B or C) |
| <input type="checkbox"/> Heart Block             | <input type="checkbox"/> Blood Clot in Lungs   | <input type="checkbox"/> Kidney Disease  | _____  |
| <input type="checkbox"/> Hereditary Heart Defect | <input type="checkbox"/> Lung Problems         | <input type="checkbox"/> Stroke          | _____  |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Diabetes        | _____  |

**Please provide information about previous surgeries and hospitalizations (include date or year)**

Surgeries / Procedures		Hospitalizations	
Coronary Bypass _____	Date _____	Admitted for _____	Date _____
Cardiac Cath _____	Date _____	_____	Date _____
Angioplasty / Stent _____	Date _____	_____	Date _____
Pacemaker _____	Date _____	_____	Date _____
Defibrillator _____	Date _____	_____	Date _____
Other _____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____

**Please provide information about previous testing (include date and location)**

Stress Test	Date _____	Location _____	Holter Monitor	Date _____	Location _____
Nuclear Test	Date _____	Location _____	Event Monitor	Date _____	Location _____
Echo	Date _____	Location _____	Heart Scan	Date _____	Location _____
24 hr BP Monitor	Date _____	Location _____	PAD Net	Date _____	Location _____

**Does anyone in your family have or had Heart Disease, Heart Attack, Stroke, High Cholesterol, High Blood Pressure, Diabetes, Diabetes, Sudden Death or Cancer?**

Father	Age _____	Disease(s) _____	Cause of death, if deceased _____
Mother	Age _____	Disease(s) _____	Cause of death, if deceased _____
Siblings	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____

**Social History:**

Cigarette Smoking: Never Current: \_\_\_\_\_ pack(s) per day, \_\_\_\_\_ year's total Previous: \_\_\_\_\_ year quit  
 Use of Alcohol: Never Rare/Social Moderate Daily: amount per day \_\_\_\_\_ Previous: \_\_\_\_\_ year quit  
 Use of Caffeine: Never Rare/Social Moderate Daily: amount per day \_\_\_\_\_ Previous: \_\_\_\_\_ year quit  
 Exercise Level: Never Rare Moderate Daily \_\_\_\_\_ times per week. Type of exercise: \_\_\_\_\_  
 Special Diet: Low Fat Low Cholesterol Vegetarian Other \_\_\_\_\_  
 Employment: Full time Part time Retired Unemployed Other \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_