



**Clinical Assessment**

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_

Work Phone Number (\_\_\_\_\_) \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Referring Cardiologist: \_\_\_\_\_

Place Identification Label Here

History Obtained from:  Patient     Family     Hospital Records     Transfer Records  
 Other \_\_\_\_\_

Major (Chief) Complaint: \_\_\_\_\_

Past Medical History:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cardiovascular History	Associated Signs/Symptoms	Risk Factors
<input type="checkbox"/> Heart Murmur <input type="checkbox"/> Stroke/TIA When? _____ <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Pulmonary Embolus/Blood Clots When? _____ <input type="checkbox"/> Bypass Surgery When? _____ <input type="checkbox"/> Angioplasty When? _____ <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Pacemaker/Defibrillator When? _____ <input type="checkbox"/> Heart Attack When? _____  <input type="checkbox"/> NONE OF THE ABOVE	<input type="checkbox"/> Dizziness on standing <input type="checkbox"/> Shortness of breath with activity <input type="checkbox"/> Awakening from sleep with shortness of breath <input type="checkbox"/> Swelling of the ankles <input type="checkbox"/> Sleeps with greater than 2 pillows <input type="checkbox"/> Palpitations <input type="checkbox"/> Passing out spells <input type="checkbox"/> Pain in legs when walking <input type="checkbox"/> Chest pain  <input type="checkbox"/> NONE OF THE ABOVE	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Minimal Exercise <input type="checkbox"/> Family history of heart disease <input type="checkbox"/> Post-menopausal/not on estrogen (Natural/Surgical) <input type="checkbox"/> Smoking _____ Packs/Day Years _____ Quit _____ <input type="checkbox"/> Overweight  <input type="checkbox"/> NONE OF THE ABOVE



Social History:     Married     Single     Significant Other     Divorced

Health Status of significant other: \_\_\_\_\_

Children: \_\_\_\_\_

Health Status of Children: \_\_\_\_\_

Occupation: \_\_\_\_\_

<p><b>Consume Alcohol</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>	<p><b>Drug Use</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>	<p><b>Tobacco Use</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>	<p><b>Caffeine Use</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>
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**REVIEW OF SYSTEMS**

<p><b>In General:</b></p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Anesthetic reaction</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> None</p> <p><b>Eyes:</b></p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p><b>Ears, Nose, Throat:</b></p> <p><input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> Vertigo/Dizziness</p> <p><input type="checkbox"/> Ringing on ears</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p><b>Skin:</b></p> <p><input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p>	<p><b>Musculoskeletal:</b></p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Amputation</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p><b>Psychiatric:</b></p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p><b>GI:</b></p> <p><input type="checkbox"/> Hiatal hernia</p> <p><input type="checkbox"/> Ulcers/bleeding from gastrointestinal tract</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Acid reflux</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p>	<p><b>Hematology:</b></p> <p><input type="checkbox"/> Easy bleeding</p> <p><input type="checkbox"/> Blood transfusions</p> <p><input type="checkbox"/> None</p> <p><b>Renal:</b></p> <p><input type="checkbox"/> Prostate</p> <p><input type="checkbox"/> Kidney dysfunction</p> <p><input type="checkbox"/> Incontinence/loss of urine</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Urinary tract infections</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p><b>Allergies &amp; Immunology:</b></p> <p><input type="checkbox"/> Immune disorder</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p>	<p><b>Respiratory:</b></p> <p><input type="checkbox"/> Sleep apnea/breathing stops while sleeping</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> None</p> <p><b>Glandular/Endocrine:</b></p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Uric acid</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p><b>Neurological:</b></p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Parkinson's</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> ALL OTHER SYSTEMS NEGATIVE</p>
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Comments on all check items:

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\_\_\_\_\_

\_\_\_\_\_

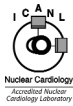
\_\_\_\_\_

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\_\_\_\_\_



Past Surgeries/Significant Illnesses:

Date:

MD/Hospital:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication (please include over the counter and vitamins)

Dosage per day

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies/Intolerances

\_\_\_\_\_

Allergic to X-Ray dye  Yes  No  Unknown

Family History

Illnesses

Deceased

Living

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother: \_\_\_\_\_

Brother: \_\_\_\_\_

Sister: \_\_\_\_\_

Sister: \_\_\_\_\_

Signature \_\_\_\_\_