DR. STACY SMITH-CARDIOLOGIST

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Patient Name:_____ Date of Visit: _____
First Last M.I.

Date of Birth:_____ Age:_____ Sex:_____ Height:_____ Weight: _____

Referring Doctor:_____ Primary Care Doctor: _____

Reason for Visit (current symptoms today):_____

Recent hospitalization? If yes, please explain: _____

Local Pharmacy Name:_____ City:_____ Ph:_____ Mail Order Pharmacy:_____ Phone: _____

Advanced Directives: ☐ None ☐ POA ☐ Living Will ☐ Healthcare Proxy

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Do You Use Tobacco: ☐ Current ☐ Former ☐ Never **If former, Age Quit:** _____

If Yes, Type: ☐ Chewing ☐ Cigarettes ☐ Pipe ☐ Smokeless

Packs/day_____ Years used_____ Passive smoke exposure: ☐ No ☐ Yes

Are you interested in tobacco cessation information? ☐ Yes ☐ No

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Have you ever been diagnosed or are taking medications for the following conditions:

Diabetes: ☐ Yes ☐ No ☐ Unknown **If Yes, Type:** ☐ Type 1 (Juvenile) ☐ Type 2 (Adult onset) **Year diagnosed**_____

High Cholesterol: ☐ Yes ☐ No ☐ Unknown

If Yes, Type: ☐ Cholesterol ☐ Triglycerides ☐ Cholesterol + Triglycerides ☐ Low HDL Syndrome

High Blood Pressure: ☐ Yes ☐ No ☐ Unknown **Year diagnosed**_____

Family History of Heart Disease (CAD) prior to age 55: ☐ Yes ☐ No ☐ Unknown ☐ Adopted (Unknown)

Peripheral Vascular Disease (poor circulation in legs): ☐ Yes ☐ No ☐ Unknown

Are you allergic to any medications: Yes ☐ No ☐

Medications you are allergic to: **Reaction:**

Other allergies (food, adhesive tape, iodine, latex, etc.):

CURRENT MEDICATIONS	DOSE (Strength)	DOSAGE (How many & times per day)
Example: Lopressor	*50 mg*	*1 tablet, two times a day*

Review of Symptoms: Check only the problems you are currently experiencing

	Y	N		Y	N		Y	N	
Cardiac:	○	○	Chest Pain (pressure)	○	○	Diaphoresis (excessive perspiration)	○	○	Orthopnea (trouble breathing lying down)
Cardiac:	○	○	Palpitation (fluttering)	○	○	Syncope (loss of consciousness)	○	○	PND (trouble breathing at night)
Vascular:	○	○	Claudication (leg pain)	○	○	Edema (swelling)			
Constitutional:	○	○	Weight Gain	○	○	Weight Loss	○	○	Fever
HEENT:	○	○	Visual Changes	○	○	Hearing Loss			
Respiratory:	○	○	Snoring	○	○	Hemoptysis (coughing up blood)	○	○	Dyspnea (shortness of breath)
Gastrointestinal:	○	○	Nausea	○	○	Reflux	○	○	Bleeding
Genitourinary:	○	○	Hematuria (blood in urine)	○	○	Nocturia (nighttime urination)			
Neurology:	○	○	Dizziness	○	○	Memory Loss	○	○	Seizures
Psychiatric:	○	○	Depression	○	○	Hallucinations			
Hematologic:	○	○	Acute Anemia	○	○	Thrombocytopenia (low platelet count)			
Endocrine:	○	○	Goiter (enlarged thyroid)	○	○	Tremors			
Derm (Skin):	○	○	Rash	○	○	Skin Sores			
Musculoskeletal:	○	○	Joint Pain	○	○	Myalgia (muscle pain)			

Past Medical History – *Place a check mark in the box for any conditions that apply:*

Respiratory: ☐ COPD ☐ Pulmonary Embolus ☐ Pulmonary Hypertension ☐ Sleep Apnea ☐ Other:_____

Renal: ☐ End Stage Renal Disease ☐ Renal Artery Stenosis ☐ Renal Insufficiency ☐ Other:_____

Endocrine: ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Obesity ☐ Other:_____

Oncology: ☐ Breast Cancer ☐ Skin Cancer ☐ Lung Cancer ☐ Prostate Cancer ☐ Other:_____

☐ Chemotherapy ☐ Radiation ☐ Other:_____

Cardiac: ☐ Arrhythmias ☐ Congestive Heart Failure ☐ CAD ☐ Heart Attack (MI) ☐ Valvular Heart Disease

☐ CABG (Bypass) ☐ Coronary Stent ☐ ICD ☐ Pacemaker ☐ PTCA (Angioplasty) ☐ Other:_____

Vascular: ☐ Abdominal Aneurysm ☐ Peripheral Arterial Disease ☐ Carotid Disease ☐ DVT ☐ Thoracic Aneurysm

☐ Varicose Veins ☐ Amputation ☐ Aneurysm Repair ☐ Vein Stripping ☐ Other:_____

List any other medical conditions: _____

_____

List any other surgeries: _____

_____

Family History – Checkmark any conditions that apply ☐ No Relevant Family History ☐ Unknown - Adopted

	Current Age	Age at Death	Heart Attack	Arrhythmia	Heart Failure	Aneurysm	Stroke	High Blood Pressure	High Cholesterol	Diabetes	Lung Disease	Renal Disease	Cancer
Mother													
Father													
Other													

Other pertinent family history:_____

_____

Do you consume Alcohol: ☐ Yes ☐ No ☐ Former **If Yes, What Type:** ☐ Beer ☐ Wine ☐ Liquor ☐ Variety

If Yes, Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially **Amount:**_____

Do you consume Caffeine on a daily basis: ☐ Yes ☐ No **Cups per day:**_____

If Yes, What type: ☐ Chocolate ☐ Coffee ☐ Energy Drink ☐ Soda ☐ Tablets ☐ Tea ☐ Other:_____

Do you follow a specific diet: (check all that apply)

☐ Diabetic ☐ Low Carb ☐ Low Fat, Low Cholesterol ☐ Low Salt ☐ No Added Salt ☐ No Specific Diet

☐ Regular ☐ Renal ☐ Vegetarian ☐ Weight Loss ☐ Other :_____

Drug use/abuse: ☐ Yes ☐ No ☐ Former **If Yes, what type:** _____

PLEASE ADD ANY ADDITIONAL INFORMATION FOR PROVIDER HERE: