

# Advanced Heart Care, PA

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Chief Complaint:

\_\_\_\_\_

\_\_\_\_\_

## Review of Systems:

1. Are you allergic to any medications?  Yes  No  
If so, please list \_\_\_\_\_
2. Recently have you been having dizzy spells?  Yes  No
3. Recently have you passed out?  Yes  No
4. Do you snore?  Yes  No
5. Do you have sleep apnea (stop breathing in your sleep)?  Yes  No
6. Do you wake in the night with shortness of breath?  Yes  No
7. Do you get short of breath laying flat on your back?  Yes  No
8. Do you get short of breath walking a short distance?  Yes  No
9. Have you ever had a stroke?  Yes  No
10. Have you ever had a mini stroke or TIA?  Yes  No
11. Do your hands or feet swell?  Yes  No
12. Do you have leg cramps in the calf muscle(s) with activity?  Yes  No
13. Do you have problems with your stomach?  
(heartburn, indigestion, acid reflux, GERD)  Yes  No
14. Do you have problems with your bowels? (i.e., constipation, diarrhea)  Yes  No
15. Recently have you been having chest pains, tightness, or heaviness?  Yes  No  
If so, have you had  Neck Pain  Jaw Pain  Left Arm Pain  
 Back Pain  Sweaty  Clammy  
 Nausea  Vomiting  Shortness of Breath  
How often does occur?  daily  weekly  monthly  
How long does it last?  sec  min  hrs  constant  
Is it with  rest  exertion  both

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16. Recently have you been having palpitations or fluttering in your chest?  Yes  No
17. Are you a free bleeder or do you have a blood clotting disorder?  Yes  No
18. Have you ever had to get a blood transfusion?  Yes  No

### Past Medical History:

19. Have you ever had Rheumatic or Scarlet Fever?  Yes  No
20. Have you ever been on Premarin or had Premarin Treatment?  Yes  No
21. Have you ever been diagnosed with Angina?  Yes  No
22. Have you ever been told or diagnosed with a heart murmur?  Yes  No
23. Have you ever been diagnosed with circulation problems in your arms or legs?  Yes  No
24. Have you ever been told or diagnosed with problems with the valves in you heart?  Yes  No
25. Have you ever had a heart attack?  Yes  No
26. Have you ever been diagnosed with Congestive Heart Failure (CHF)?  Yes  No
27. Have you ever been told or diagnosed with an aneurysm in you abdomen?  Yes  No
28. Have you ever been told or diagnosed with an aneurysm in you head?  Yes  No
29. Have you ever had CPR done on you?  Yes  No
30. Have you ever had a blood clot in your leg(s)?  Yes  No
31. Have you ever had a blood clot in your lungs?  Yes  No
32. Have you ever been diagnosed with Chronic Obstructive Pulmonary Disease (COPD), asthma, or emphysema?  Yes  No
33. Have you ever been diagnosed with thyroid problems?  Yes  No

### Surgical History:

34. Have you ever had a Cardiac Cathetization (angiogram, heart dye test) done?  Yes  No
35. Have you ever had an Angioplasty (heart stent, heart balloon)?  Yes  No
36. Have you ever had heart bypass surgery (CABG)?  Yes  No

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37. Have you ever had a heart valve replaced or repaired?  Yes  No
38. Have you ever had a Carotid Endarterectomy (CEA) or neck artery surgery?  Yes  No
39. Have you ever had a Peripheral Angioplasty (PTA)?  Yes  No  
(balloon or stent in the leg(s), arm(s), subclavian artery, renal artery)
40. Do you have a Pacemaker? If so, what company? \_\_\_\_\_  Yes  No
41. Do you have a Defibrillator?  Yes  No
42. Have you had a hysterectomy?  Yes  No
43. Have you had your ovary(s) removed?  Yes  No
44. Have you had a tonsillectomy and/or adenoidectomy?  Yes  No
45. Have you had any other surgeries?  Yes  No  
If so, please list: \_\_\_\_\_  
\_\_\_\_\_

### Risk Factors:

46. Have you been diagnosed with high blood pressure (hypertension)?  Yes  No
47. Do you have high cholesterol?  Yes  No
48. Do you have diabetes?  Yes  No  
Is it controlled by  diet  pills  shots/insulin
49. Do you or have you ever used tobacco?  Yes  No  
If so, how many packs/cans/pouches per day? \_\_\_\_\_ How many years? \_\_\_\_\_
50. Have you quit smoking? If so, how many years have you quit? \_\_\_\_\_  Yes  No

### Family History:

51. Is your father  alive or  deceased? How old? \_\_\_\_\_  
Health Problems: \_\_\_\_\_
52. Is your mother  alive or  deceased? How old? \_\_\_\_\_  
Health Problems: \_\_\_\_\_
53. Do you have any brothers?  Yes  No  
How many are  alive  deceased?  
Health Problems: \_\_\_\_\_



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