South Denver Cardiology Associates, P.C.

Today's Date: _____

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

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
Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Declined

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 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	Leg cramps with walking	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

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