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: ______________________

Reason for today's visit: ______________________

Referring physician and all physicians to send report of visit: ______________________

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 ______________________

SOCIAL HISTORY

Occupation: ______________________

Marital Status (circle) Single Married Divorced Widowed Separated

Alcoholic drinks (average per week) ____________ Street 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? ______________________

Family History

Please list parents, children, grandparents, aunts and uncles with the following illnesses: Heart Disease, strokes, diabetes, high blood pressure

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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 Changes	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 at night	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

Have you been told you stop breathing during sleep? YES NO

Are you excessively tired during the day? YES NO

Is your neck size >17” (male) and >16” (female)? YES NO