

**PLEASE PRINT**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Check symptoms/conditions you currently have or have had in the past that may indicate cardiac or heart disease.**

- \_\_\_\_\_ Family history of cardiac or heart disease
- \_\_\_\_\_ Heart Disease
- \_\_\_\_\_ Heart Attack
- \_\_\_\_\_ Heart Surgery
- \_\_\_\_\_ Heart Stents
- \_\_\_\_\_ Chest Pain
- \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Low Blood Pressure
- \_\_\_\_\_ Irregular Heart Beat
- \_\_\_\_\_ Rapid Heart Beat
- \_\_\_\_\_ Pacemaker
- \_\_\_\_\_ Dizziness or Lightheadedness
- \_\_\_\_\_ Fainting/Near Fainting
- \_\_\_\_\_ Blurred vision
- \_\_\_\_\_ Vertigo
- \_\_\_\_\_ Passing Out
- \_\_\_\_\_ Shortness of Breath
- \_\_\_\_\_ Decrease in Exercise Capacity

**Check symptoms/conditions you currently have or have had in the past that may indicate leg or arm Peripheral Vascular Disease (PAD/PVD).**

- \_\_\_\_\_ Numbness or tingling of the arms, legs, or feet
- \_\_\_\_\_ Cold or “cool to the touch” of the arms, legs, or feet
- \_\_\_\_\_ Thick skin/thickening of the skin or dark skin of the legs around/above the ankles
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ TIA
- \_\_\_\_\_ Wounds/Sores that will not heal
- \_\_\_\_\_ Peripheral Artery Disease (PAD/PVD)
- \_\_\_\_\_ Varicose Veins or Spider Veins
- \_\_\_\_\_ Venous Insufficiency
- \_\_\_\_\_ Blue Discoloration of the toes
- \_\_\_\_\_ Kidney Disease
- \_\_\_\_\_ Dialysis
- \_\_\_\_\_ Decrease in exercise capacity
- \_\_\_\_\_ Abdominal pain or swelling
- \_\_\_\_\_ Abdominal pain after eating
- \_\_\_\_\_ Leg pain when walking
- \_\_\_\_\_ Leg pain while sitting/laying down
- \_\_\_\_\_ Leg weakness
- \_\_\_\_\_ Swelling of the legs/ankles
- \_\_\_\_\_ Swelling of the arms



**PLEASE PRINT**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MEDICAL HISTORY: LIST SURGERIES IN THE PAST YOU HAVE HAD AND THE YEAR**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**FAMILY HISTORY: LIST ANY ILLNESSES THAT ARE IN YOUR FAMILY**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**SOCIAL HISTORY: CHECK THE SUBSTANCE YOU USE AND DESCRIBE HOW MUCH YOU USE**

1. \_\_\_\_\_ **CAFFEINE** \_\_\_\_\_

2. \_\_\_\_\_ **TOBACCO** \_\_\_\_\_

3. \_\_\_\_\_ **ALCOHOL** \_\_\_\_\_

4. \_\_\_\_\_ **OTHER** \_\_\_\_\_

