Name _____
DOB: _____
Date: _____

Heart Consultants, LLC

PAST MEDICAL HISTORY:
☐Rheumatic Fever ☐Scarlet Fever ☐Heart Murmur ☐High Blood Pressure
☐Diabetes ☐High/Bad Cholesterol ☐Lung Disease/Asthma ☐Emphysema/COPD ☐Stroke ☐Bleeding Problems
☐Seizures ☐Other _____☐None of the Above

☐Past Surgeries_____

FAMILY HISTORY: ☐High Blood Pressure ☐Diabetes ☐High Cholesterol ☐Coronary Artery Disease
☐Heart Attack ☐Angina ☐Bypass Surgery ☐Sudden Death ☐Heart Failure ☐Stroke ☐Seizures
☐Other _____ ☐None of the Above

SOCIAL HISTORY: ☐Married ☐Single ☐Divorced ☐Widowed

Occupation: _____

Do you do any of the following?

1. Smoke: ☐No ☐Yes If so, how many packs per day? _____
2. Have you smoked in the past? ☐No ☐Yes If so, how many packs per day? _____
3. Drink Coffee/Soft drinks/Tea: ☐No ☐Yes If so, how many cups per day? _____
4. Have you in the past? ☐No ☐Yes If so, how many cups per day? _____
5. Drink Alcohol: ☐No ☐Yes if so, how much/how often? _____
6. Have you in the past? ☐No ☐Yes If so, how much/how often? _____
7. Use illegal street drugs: ☐No ☐Yes If so, what drug? _____
8. Have you used in the past? ☐No ☐Yes If so, what drug? _____
9.

Check all that apply

REVIEW OF SYSTEMS:

1. ☐Hearing Loss ☐Vision Changes ☐Changes in Taste ☐Changes in Smell ☐None of the Above
2. Do you experience any of the following?☐Chills ☐Fever ☐Sweat ☐Recent Weight Loss/Gain ☐None
3. ☐Cough ☐Sputum ☐Cough up blood ☐Wheezing ☐None
4. ☐Vomiting blood ☐Painful or difficulty swallowing ☐Blood in stool ☐Black tarry stool ☐Chronic Diarrhea ☐None
5. ☐Urinary Problems ☐Erectile Dysfunction ☐Abnormal Periods ☐Abnormal Bleeding ☐None
6. ☐Arthritits ☐Rheumatism ☐Spinal Disc Disease ☐Painful Muscles ☐Painful Joints ☐None
7. ☐Easy Bleeding ☐Bruising ☐None

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8. ☐Burning/Cold hands and feet ☐Balance Problems ☐Chronic Headaches ☐Weakness ☐None
9. ☐Painful or Swollen Lymph Nodes ☐None
10. ☐Sores that do not heal properly ☐None
11. ☐Anxiety ☐Depression ☐None
12. ☐Sleep difficulty ☐Daytime Sleepiness ☐Sleep Apnea ☐Loud Snoring ☐None

Other:_____
_____