Heart One ASSOCIATES

Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any questions, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you.

Date: _____

Name: _____ **Date of Birth**: _____ **Age**: _____

Referring Physician: _____

Reason for Visit: _____

How did you hear about us?

☐ Website ☐ Hospital ☐ Friend/Relative ☐ Referral from PCP ☐ Insurance
☐ Add/Newspaper ☐Drive by ☐ Word of mouth ☐ Other _____

Personal Medical History:

Disease/Condition	Yes	No	When were you diagnosed?
Heart attack (Myocardial Infarction)			
Heart surgery (Bypass)			
Heart Valve disease			
Heart Valve surgery (Replacement/Repair)			
Peripheral Vascular Disease			
Vascular Surgery			
Congestive Heart Failure			
High Blood Pressure (Hypertension)			
Diabetes Mellitus (Type I or II)			
High Cholesterol (Hypercholesterolemia)			
History of Stroke or TIA			
Thyroid Problem			
Bleeding/Clotting Tendencies			
History of Cancer (Malignancy)			
Lung Disease			
History of Kidney Disease			
Other Problems:			

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Medications: Prescription and non-prescription medicines, home remedies, birth control pills, herbs.

Medication	Dose	How many/Day	Medication	Dose	How many/Day

Allergic to Iodine, Shellfish, or x-ray dye: ☐ No ☐ Yes

Medications you are allergic to: Reaction:

_____ _____

_____ _____

Cardiac Testing History: Please indicate whether you had any of the following tests performed?

Procedure/Test	Yes	No	Where/When?
Heart Catheterization of Angiogram			
Heart Stent			
EKG			
Nuclear Stress Test			
Echocardiogram			
Carotid ultrasound			
CT Angiogram			
Electrophysiology Study			

Family History: Please indicate the current status of your immediate family members:

Relation	Alive	Deceased	Age (Now or at death)	Comments/Cause of Death
Mother:				
Father:				
Sister (s) #____				
Brother (s) #____				
Daughter (s) #____				
Son (s) #____				

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Occupation:_____ Employer:_____

Years of Education/Highest Degree_____ Marital status ☐ S ☐ M ☐ D ☐ W Other:___

Spouse/Partner's Name:_____ Number of Children/Ages:_____

Who lives at home with you? _____

Social History

Tobacco Use: ☐ Current ☐ Former ☐ Never If former, Year Quit: _____

If Yes, Type: ☐ Chewing ☐ Cigarette ☐ Pipe ☐ Smokeless

Packs/day _____ Years Used _____ Passive Smoke Exposure ☐ No ☐ Yes

Alcohol Use: Do you drink alcohol? ☐ No ☐ Yes # of Drinks /Week: _____

Drug Use: Do you use recreational use? ☐ No ☐ Yes

Have you ever used needles? ☐ No ☐ Yes

Sexually Active: ☐ No ☐ Yes ☐ Not Currently

History of Erectile Dysfunction (Males Only): ☐ No ☐ Yes

Do you consume Caffeine on a daily basis: ☐ Yes ☐ No Cups per day _____

If Yes, What Type: ☐ Sodas ☐ Coffee/Tea ☐ Energy Drink ☐ Chocolate ☐ Other: _____

Weight: Are you satisfied with your weight? ☐ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise: Do you exercise regularly? ☐ No ☐ Yes

What kind of exercise? _____ How long (minutes)? _____ How often? _____

If you do not exercise, why? _____

Advanced Directives: ☐ None ☐ DNR ☐ HC Proxy ☐ Living Will

Do you have a POA? YES ____ No____ If yes who is your designated POA _____

Relationship: _____ Phone #:_____

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Review of Systems: Please check (✓) any current problems you have on the list below:

Constitutional _____ Fever/Chills/Sweats _____ Unexplained weight loss/gain _____ Change in Energy/Weakness _____ Excessive thirst or urination	**Genitourinary** ____Nighttime urination ____Leaking urine ____Unusual vaginal bleeding ____Discharge: penis or vagina
Eyes _____ Change in Vision	**Musculoskeletal** ____Muscle/joint pain
Chest (breast) ____Breast lump/nipple discharge	**Skin** ____Rash/Mole Change
Cardiovascular ____Chest pain/discomfort _____ Palpitations _____ Shortness of breath _____ Ankle Edema	**Neurological** ____Headaches ____Dizziness/Lightheaded ____Numbness ____Memory Loss ____Loss of coordination
Ears/Nose/Throat/Mouth ____Difficult hearing/ringing in ears ____Problems with teeth/gums ____Hay Fever/Allergies	**Psychiatric** ____Anxiety/Stress ____Problems with sleep ____Depression
Respiratory ____Cough/Wheeze ____Difficulty Breathing	**Gastrointestinal** ____Abdominal pain ____Blood in bowel movement ____Nausea/Vomiting/Diarrhea
Blood/Lymphatic ____Unexplained lumps ____Easy bruising/bleeding	**Other** _____ Problems with sexual function

Vitamins & Supplements: Please check (✓) any supplements that you are currently taking:

Supplement	**Dose**	**Supplement**	**Dose**
____Multivitamins	_____	____Beta Carotene	_____
____Vitamin B3 (niacin)	_____	____Calcium	_____
____Vitamin B6	_____	____Garlic	_____
____Vitamin B12	_____	____Magnesium	_____
____Vitamin B Complex	_____	____Mineral Supplement	_____
____Vitamin C	_____	____Omega-3 Fatty Acid	_____
____Vitamin D	_____	____Potassium	_____
____Vitamin E	_____	____Zinc	_____
____Herbal/black/green Tea	_____	____Saw Palmetto	_____
____Herbal Mixtures	_____	____St. John's Wort	_____
____Ma huang/ephedra	_____	____Metabolite	_____
____Plant Steroids	_____	____Ginkgo	_____
____Grape Seed Extract	_____	____Other_____	