Date:

Patient Data Sheet

Name: _____**DOB**:_____**Age**:_____
Reason for visit: _____
Primary Care MD: _____**Referring MD**: _____
Medications: _____
_____
_____
_____
_____

Allergies: Drugs/Shellfish/Dye/Environmental_____Rash/Wheeze/Swelling_____

Past Medical History:

Heart Attack(s)	Y/N	Date(s) _____	Rheumatic Fever/ Valve disease	Y/N
Congestive Heart Failure	Y/N	Date(s) _____	COPD/Asthma	Y/N
Stroke(s)	Y/N	Date(s) _____	Sleep Apnea	Y/N
Diabetes		Y/N	GI Bleeding	Y/N
High Blood Pressure		Y/N	Arthritis	Y/N
High Cholesterol		Y/N	Kidney/Prostate Disease	Y/N
Aortic Aneurysm/Arterial Disease		Y/N	History of Blood Clots	Y/N
Arrhythmia/ Pacer/Defib		Y/N	Thyroid Disease	Y/N

Surgical History/ Hospitalizations: _____
_____
_____
_____
_____

Cardiovascular Tests/Procedures (Circle positive responses; enter dates):

ECG_____ Stress Test_____Echocardiogram_____
Nuclear Scan_____ Cardiac Cath_____Stent Implant_____
Heart Surgery_____EP/Ablation_____ Pacer/Defib. Implant_____
Carotid Scan_____PAD Screen/ABI_____

Family History: Premature Death (<=55 M, <=65 F):_____
Heart Disease_____Diabetes:_____High Cholesterol_____
High Blood Pressure_____ _____Stroke_____
Cancer_____

Social History: Living with spouse/family/alone

Tobacco use_____ /day, for_____ years Quit Date_____ N/A
Alcohol use_____ /day, for_____ years Quit Date_____ N/A
Illicit drug use _____ Quit Date _____ N/A
Caffeine use (Tea/Coffee/Soda)_____
Exercise Habits/Occupation_____

Updated: 07/21/2012

Review of Systems: (Circle positive responses)

Constitutional: Weight loss, fever, poor appetite_____

Eyes: Glaucoma, cataracts_____

Ears/Nose/Mouth/Throat: Hearing aids (R/L), dentures, ringing in ears, runny nose, sore throat_____

Heart: Chest/left arm/jaw pain, shortness of breath, difficulty lying, fluttering heart beat, dizziness, fainting, ankle swelling, leg pain with exertion* _____

Respiratory: Cough, mucous, wheezing, oxygen use, snoring/CPAP use_____

Gastrointestinal: Swallowing trouble, nausea, vomiting, diarrhea, constipation, acid reflux, blood in stools_____

Genito-urinary: Irregular periods, last period (_____), weak stream, leakage, frequent urination, burning, incomplete emptying, blood in urine, erectile dysfunction*_____

Musculoskeletal: Muscle soreness, joint pains, back pain_____

Skin: Rashes, bruising, slow healing ulcers*, cold feet/loss of hair*_____

CNS: Numbness, tingling, weakness, transient loss of vision, gait problems, seizures_____

Psychiatric: Depression, anxiety, insomnia_____

Endocrine: Overactive/underactive thyroid, diabetes_____

Hematologic/lymphatic: Anemia, bleeding, lymph node swelling_____ _____

Allergy/Immunology: Hay fever, hives, swelling of lips/tongue/throat/eyelids, food/drug allergies_____

Patient Signature: _____ Date: _____

THIS BOX FOR OFFICE USE ONLY	**Checked By: _____**	**Date: _____**
Height: _____	**Weight: _____**	**BMI: _____**
Pulse: _____bpm	**BP: _____ mmHg.**	**Pulse Ox: _____ %**

Notes_____

*suggests peripheral vascular disease