

# Mid-Ohio Heart Clinic, Inc.

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## (Please Print)

Today's Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Phone: \_\_\_\_\_  
Full Name \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Family Physician: \_\_\_\_\_

## CURRENT PROBLEMS YOU WISH TO DISCUSS:

When did it begin? \_\_\_\_\_ Is it worse at night or during the day? \_\_\_\_\_  
Frequency \_\_\_\_\_ (times per day, week, etc.) Duration \_\_\_\_\_ (hours, days, etc)  
What do you think makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_  
Associated nausea?  Yes  No Associated sweatiness?  Yes  No

## RECENT SYMPTOMS: Do you have:

Pressure or pain in chest with activity:  Yes  No At night:  Yes  No  
Leg discomfort while walking:  Yes  No Ankle swelling:  Yes  No  
Light-headedness, fainting, dizziness:  Yes  No Heart Palpitations:  Yes  No  
Shortness of breath at rest:  Yes  No With activity:  Yes  No At night:  Yes  No

## CARDIAC RISK FACTORS: Have you had:

A heart attack:  Yes  No Congestive Heart Failure:  Yes  No Diabetes:  Yes  No  
High blood pressure:  Yes  No High cholesterol/Triglycerides:  Yes  No  
Rheumatic Fever:  Yes  No Sleep Apnea:  Yes  No Do you smoke?  Yes  No  
Circulation problems?  Yes  No If yes, of: \_\_\_\_\_ Arms \_\_\_\_\_ Neck \_\_\_\_\_ Legs \_\_\_\_\_ Heart \_\_\_\_\_ Lungs  
Family history of heart attacks or heart surgery?  Yes  No

## ALLERGIES \_\_\_\_\_

## MEDICATIONS: (List all medications including vitamins, minerals, herbs, aspirin, etc.)

	Medication	Dose	Frequency	Start Date
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

Please turn over to complete →

**Have you had:**

A heart catheterization  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
Balloon Angioplasty  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
Open heart surgery  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
A stress test  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
An EKG  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
An echocardiogram  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
A holter monitor  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
A pacemaker/AICD  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_  
Heart Rhythm Evaluation/Ablation  Yes  No When \_\_\_\_\_ Where \_\_\_\_\_

**Have you had:**

Cancer \_\_\_\_\_ Stomach Ulcers \_\_\_\_\_ Bleeding/Clotting Problems \_\_\_\_\_  
Gout/Arthritis \_\_\_\_\_ Hiatal Hernia \_\_\_\_\_ Kidney Problems \_\_\_\_\_  
Fever \_\_\_\_\_ Thyroid Problems \_\_\_\_\_ Stroke/Neurological Problems \_\_\_\_\_  
Liver Problems \_\_\_\_\_ Muscle/Bone Problems \_\_\_\_\_ Aneurysm \_\_\_\_\_  
HIV/STD \_\_\_\_\_ Lung Disease/COPD \_\_\_\_\_ Bowel/Bladder Problems \_\_\_\_\_  
Anemia \_\_\_\_\_ Sexual Dysfunction \_\_\_\_\_ Gynecological Problems/Miscarriages \_\_\_\_\_  
Vision Problems \_\_\_\_\_ Hearing Problems \_\_\_\_\_ Skin Rashes/Diseases \_\_\_\_\_  
Glaucoma \_\_\_\_\_ Prostate Problems \_\_\_\_\_ Unusual weight loss/gain \_\_\_\_\_  
Any Heart Rhythm Problems (Atrial Fibrillation, palpitations, arrhythmia) \_\_\_\_\_  
Other \_\_\_\_\_

**SURGICAL HISTORY:**

Please list all major surgeries:

	Surgery	When	Where
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

**FAMILY HISTORY:**

	Living/Deceased	Age	Cause of Death	Had they ever had a heart attack? Age?	High Cholesterol
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____

**SOCIAL HISTORY:**

Married  Single  Divorced  Widowed: How many children? \_\_\_\_\_  
How much caffeine do you drink? \_\_\_\_\_ How much alcohol? \_\_\_\_\_  
Have you ever taken recreational drugs?  Yes  No What type \_\_\_\_\_  
Do you smoke?  Yes  No If yes, how many packs a day do you smoke? \_\_\_\_ For how long? \_\_\_\_\_  
When did you quit? \_\_\_\_\_ Are you on a special diet? \_\_\_\_\_  
Do you exercise regularly?  Yes  No Type of exercise \_\_\_\_\_ How Often? \_\_\_\_\_

**New Patients and as reviewed:**

Physician Signature/Initials \_\_\_\_\_ Date \_\_\_\_\_ Physician Signature/Initials \_\_\_\_\_ Date \_\_\_\_\_  
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