NORTHSIDE HEART

Date of birth _____ /_____ /_____
Month Day Year

"Office Use Only"
Data Entered by: _____

Patient Name: _____ **Date:** _____

Age: _____ Sex: M F

Chief Complaint: _____

Who is your Primary Care Physician? _____ Phone# _____

CARDIAC HISTORY

Do you have chest pain? Yes

If so, when did it begin? _____

What is its frequency? _____

What is the duration of pain?	(seconds)	(minutes)	(hours)	(days)		
The pain worse with:	(stress)	(exercise)	(meals)	(sleep)	(position)	(other)
The pain is better with:	(rest)	(aspirin)	(nitroglycerin)	(other)		
What does the discomfort feel like?	(sharp)	(aching)	(burning)	(tightness)	(pressure)	

Have you had any of the following cardiac studies? Please fill in date of study if applicable.

Exercise Treadmill	Echo	Nuclear Scan	Catherization
Date _____	Date _____	Date _____	Date _____

Please circle yes if this applies to you:

Do you get any skipped heartbeats or racing heart?	Yes	No
Do you have shortness of breath while lying flat?	Yes	No
Do you wake up with shortness of breath?	Yes	No
Do you get swelling of the ankles?	Yes	No
Do you get calf pain while walking?	Yes	No
Have you ever fainted?	Yes	No

Please list the name, dosage and frequency of current medications:

MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT INTAKE FORM

Patient Name: _____ **Date:** _____

ALLERGIC/IMMUNOLOGIC

Do you have any drug allergies? Yes No

History of skin reaction or other adverse reactions to:

Antibiotics: Name _____

Pain medication: Name _____

Anesthetics: Name _____

Blood thinners: Name _____

Contrast agents, iodine, dyes or shellfish: Name _____

Other drugs or medication: Name _____

Known food allergies Name _____

FAMILY HISTORY

Does anyone in your family have a history of:

☐ Heart disease Relationship _____

☐ Heart surgery Relationship _____

☐ Hypertension Relationship _____

☐ Diabetes Mellitus Relationship _____

☐ Stroke Relationship _____

☐ Vascular problems Relationship _____

Age of mother _____ Age of father _____ Number of siblings _____

If parents or siblings are not living, please list age and cause of death:

Father- age _____ Cause _____

Mother- age _____ Cause _____

Sibling- age _____ Cause _____

CARDIAC RISK FACTORS

Please circle yes if this applies to you:

History of stroke/peripheral circulation problems? Yes No

Do you have a history of high blood pressure? Yes No number of years _____

Do you have a history of diabetes mellitus? Yes No number of years _____

Have you ever been told that you have elevated cholesterol? Yes No number of years _____

If so, what is your level? Total cholesterol _____ "Bad" cholesterol _____

Do you smoke? Yes No number of years _____ cigs per day _____

If no, have you ever smoked before? Yes No year quit _____

Do you exercise regularly at least 30 minutes 3 times per week? Yes No

Please circle appropriate exercise activity: (Walk) (Run) (Aerobics) (Sports)

Patient Name: _____ **Date:** _____

PAST HISTORY

Please list any surgical procedures, major illnesses, hospitalizations and their dates:

NAME	DATE
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Where were you born? _____ If outside the US, what year did you come to the states? _____

How would you describe your ethnic background? _____

Are you: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced ☐ Life partner

Do you have any children? Yes No If yes, how many? _____ What are their ages? _____

Are you employed? Yes No If yes, what is your job title? _____

Occupation: Please state an accurate description of your work activity:

_____

_____

If retired, what did you do before? _____

What is your favorite activity? _____

Do you exercise? ☐ Yes, If 'yes indicate the frequency by checking below ☐ No:

____ Sedentary (Sitting) ____ Minimally (Once per Week) ____ Active (no formal exercise routine)

____ Moderately (1-3 times weekly) ____ Regularly (Consistently) ____ Heavily (greater than 4 times weekly)

Do you drink or indulge in any of the following substances and if so, please indicate the frequency:

Alcohol	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Caffeine	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Cocaine	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Depressants	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Illicit Drugs	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
	If 'yes', please list the type of substance: _____					
Marijuana	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
Tobacco	☐ Yes:	____ Daily	____ Occasionally	____ Seldom	____ Rehabilitated	☐ No (Never)
	If 'yes', please list the type of substance: _____					
	How often? _____	*How much (example: cigarettes 1 pack)?* _____				

Do you have any stressful problems? (Please circle) Family Work

Describe: _____

_____

Please list any questions you have for your doctor:

1. _____
2. _____
3. _____
4. _____

PLEASE CONTINUE TO NEXT PAGE

Patient Name: _____ **Date:** _____

REVIEW OF SYSTEMS

Please circle all that apply

Constitutional
Fatigue
Fever
Weight Gain
Weight Loss
Chills
General Good Health

HENT
Headaches
Nose Bleeding
Problems Swallowing

Cardiovascular
Chest Pain
Shortness of Breath w/Exercise
Heart Racing/Skipping
Irregular Heart Beats
Dizziness
Dizziness when Standing Up
Lightheadness
Fainting
Swelling
Leg Pain with Walking
Waking at Night w/Difficulty Breathing
Palpitations

Respiratory
Shortness of Breath
Wheezing
Coughing
Sleep Apnea
Sleep Problems

Gastrointestinal
Nausea
Vomiting
Diarrhea
Blood in Stool

Genitourinary
Blood in Urine
Difficulty Urinating

Integument
Rash

Neurologic
One Sided Weakness
Seizures

Musculoskeletal
Muscle Aches
Muscle Cramps

Psychiatric
Anxiety
Depression

Heme-Lymp
Easy Bleeding