AD02

Advanced Cardiology Associates
History Sheet

Patient Name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex:_____ Height:_____ Weight:_____

Occupation:_____ Family Physician:_____

Pre – Operative clearance for surgery_____ Flying or leaving the country in the next 5 days_____

Do you have any of the following

Chest pain_____

If yes: how long have you been having chest pain_____ How often does it occur_____

How long does it last_____ Where in your chest is it located_____

How severe is your chest pain on a scale of 1 to 10_____ (1 being mild and 10 being severe)

Is your chest pain associated with any specific activity_____

How is chest pain normally resolved_____

Have you been treated for chest pain before_____ Does the pain radiate_____

Class I (more than routine) **Class II** (Routine activity) **Class III** (Minimal Activity) Class **IV**(chest pain at rest)

Shortness of Breath _____

If yes: How long has shortness of breath been experienced_____ How often does it occur_____

How long does it last_____ Is shortness of breath associated with any specific activity_____

How severe on a scale of 1 to 10_____ (1 being mild and 10 very severe).

How is shortness of breath normally resolved_____

Class I (more than routine) **Class II** (Routine activity) **Class III** (Minimal Activity) **Class IV** (SOB at rest)

Congestive heart failure_____

Cardiac Catherization _____

Angioplasty _____How many stents_____

When_____

By-Pass Surgery _____How many vessels_____

When_____

Heart Attack _____

Atrial Fibrillation _____

Palpitations or irregular heart beat_____

Pacemaker _____Internal Defibrillator_____

High blood pressure _____

High Cholesterol _____

Diabetic _____Insulin Dependent_____

Indigestion _____

Light Headedness: _____

Dizziness _____

Passed out _____

Rheumatic Fever _____

Heart Infection _____

Valve Surgery _____

Valve Disease _____

Carotid surgery _____

Confusion spells _____

Stroke or Mini Stroke _____

Loss of Vision _____

Abdominal Aortic Aneurysm _____

Kidney disease _____

Stent or by pass in your legs_____

Pain in legs with walking_____

Swelling of legs _____

Have you ever had a blood clot_____

Night Sweats _____

Do you drink Alcohol _____

Coffee/Caffeine _____

Emphysema / COPD _____

Smoke _____ PPD_____How many years_____

Family History of heart disease_____ Who_____

Please list all medications you take or give front desk a list to copy so we can attach to this paper

_____

Did you take your medication today_____ Any Allergies to medications_____ If yes what_____

Any other history / congenital heart problems

_____

Technician Signature _____ Physician Signature_____