Cardiac EP Consultants,S.C.

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PATIENT HISTORY

NAME_____ **DATE**_____ **DATE OF BIRTH**_____

GENDER M / F **MARITAL STATUS** M W D S **CHILDREN**: # SONS_____ # DAUGHTERS_____

RETIRED YES / NO **OCCUPATION**_____

LIVING SITUATION: ALONE OR WITH SPOUSE/DOMESTIC PARTNER, ASSISTED LIVING OR NURSING HOME

REFERRING PHYSICIAN_____ **PRIMARY CARE PHYSICIAN**_____

REASON FOR VISIT_____

DO YOU:

Tobacco Use	No / Yes	If yes, How long, _____, How much_____, Quit date_____
Drink Alcohol	No / Yes	Ever Heavy or daily use No / Yes If yes, How much_____ How long_____
Drink Caffeine	No / Yes	How much_____
Recreational Drugs	No / Yes	

Have difficulty with Anesthesia No Yes

Weight _____ Height _____

Recent Weight Change	No / Yes	Difficulty Walking	No / Yes
Fever/chills	No / Yes	Depression	No / Yes
Fatigue	No / Yes	Anxiety	No / Yes
Wear Corrective Lenses	No / Yes	Nausea/Vomiting	No / Yes
Blurred/Double Vision	No / Yes	Diarrhea	No / Yes
Hearing Loss	No / Yes	Weakness in hands, arm, legs	No / Yes
Headaches	No / Yes	Constipation	No / Yes
Rash	No / Yes	Abdominal Pain	No / Yes
Bleeding/bruising	No / Yes	Blood in Stool	No / Yes
Chest Pain	No / Yes	Pain / burning urination	No / Yes
Palpitations	No / Yes	Blood in Urine	No / Yes
Shortness of Breath	No / Yes	Dizziness	No / Yes
Wheezing	No / Yes	Waking at night w/shortness of breath	No / Yes
Passing out	No / Yes	Shortness of breath lying flat	No / Yes
Joint Pain	No / Yes	Pain in leg with walking	No / Yes
Swelling in Joint	No / Yes		

Patient: _____

ALLERGIES

NAME	TYPE OF REACTION

FAMILY HISTORY

	FATHER	MOTHER	OTHER (siblings, children, Aunts, Uncles, Grandparents, etc.)
Coronary Artery Disease			
Heart Rhythm Problems			
Heart Failure			
Cardiac Arrest			
Heart Attack			
Devices (Pacemaker / Defibrillator)			
Stroke			
High Blood Pressure			
Diabetes			
Faint			
Elevated Cholesterol			

PAST MEDICAL HISTORY

Have YOU now or in the past ever had any of the following problems (place an X next to items)

_____ Fast Heart Rate
_____ Slow Heart Rate
_____ Irregular Heart Rate

_____ Coronary Artery Disease
_____ Heart Valve Problems
_____ Heart Failure
_____ Cardiac Arrest
_____ Heart Attack Date_____

Other Medical Problems:

_____ Low Blood Pressure
_____ High Blood Pressure
_____ Elevated Cholesterol
_____ Diabetes

_____ Stroke
_____ TIA (mini strokes)
_____ Fainting
_____ Dizziness

_____ Asthma
_____ COPD
_____ Psychological Problems
_____ Alcohol Abuse
_____ Sleep Apnea
_____ Carotid Artery Disease
_____ Cancer

Pharmacy Name: _____ Tel: _____
Location: _____ Fax: _____

Patient:_____

PREVIOUS TESTS / PROCEDURES

	DATE	WHERE
Cardiac Catheterization (Angiogram)		
Echo (Heart Ultrasound)		
EKG		
Electrophysiology Study		
Stress Test		
Ablation		
Stent – Heart		
Tilt Test		
Event Monitor		
24 Hr Monitor		

PREVIOUS SURGERIES

	DATE	HOSPITAL
HEART / CARDIAC		
Bypass Surgery		
Valve Surgery		
Permanent Pacemaker		
Defibrillator Implant		
Cardiac Transplant		
OTHER SURGERIES		

MEDICATION HISTORY

MEDICATION	DOSAGE	HOW OFTEN	SINCE WHEN	REASON	PRESCRIBING PHYSICIAN