

# Cardiac EP Consultants,S.C.

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[www.cardiacep.com](http://www.cardiacep.com)

## 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

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Have difficulty with      Weight \_\_\_\_\_      Height \_\_\_\_\_  
Anesthesia      No      Yes

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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: \_\_\_\_\_

Location: \_\_\_\_\_

Tel: \_\_\_\_\_

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