Patient Information Form

Cardiologists at Durham Cardiology

PLEASE CHECK OFF YES/NO AND FILL IN THE BLANKS ON BOTH SIDES OF THE FORM:

Background Information

Name / Age:

Family doctor:

Pharmacy:

Reason for Visit:

Cardiologist /Specialists:

Risk Factors for Heart Disease

	Yes	No
Ever Smoked?	☐	☐
Still Smoking? → when quit? _____	☐	☐
High Blood Pressure → average _____	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
Sleep Apnea/CPAP?	☐	☐
Vessel disease / Stent?	☐	☐

Past Heart Conditions

	Yes	No
Chest pain assessment → When? _____	☐	☐
Heart Attack → When? _____	☐	☐
Pericarditis → When? _____	☐	☐
Congestive Heart Failure → When? _____	☐	☐
Heart Valve Problem → Details? _____	☐	☐
Atrial Fibrillation/ Flutter → When? _____	☐	☐

Past Heart Tests

	Yes	No
Holter Monitor	☐	☐
Stress Test or Nuclear Test	☐	☐
Echo or Ultrasound of the Heart	☐	☐
Angiogram	☐	☐
Angioplasty or Stent	☐	☐
Bypass Surgery	☐	☐
Pacemaker / Defibrillator	☐	☐
Valve surgery	☐	☐

Past Medical Conditions

	Yes	No
Acid Reflux/Heart Burn	☐	☐
Stomach Ulcer or Blood in Stool	☐	☐
Blood Clot in Legs or Lungs	☐	☐
Dilated Aorta or Aortic Aneurysm	☐	☐
COPD/emphysema	☐	☐
Asthma	☐	☐
Kidney Disease	☐	☐
Anxiety /Depression	☐	☐
Stroke or TIA	☐	☐
Varicose Veins	☐	☐

Other Medical Conditions or Hospital Admissions/ Surgeries

Please List:

-
-
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Medications (Prescriptions, Aspirin, Over the Counter, Herbal)
Please List With Doses:

Allergies to Medications

Please List:

☐ **No Known Medication Allergies**

Family History of Heart Disease

List Family Members with Heart Problems:
(Including Those Who Have Passed Away)

Current Symptoms

	Yes	No
Chest Pain?	☐	☐
Shortness of Breath?	☐	☐
Do You Sleep on More Than One Pillow at Night?	☐	☐
Do You Wake Up at Night Feeling Short of Breath? Gasping for Air?	☐	☐
Palpitations/Heart Racing?	☐	☐
Dizziness/lightheaded?	☐	☐
Fainting / Passing Out	☐	☐
Leg Swelling	☐	☐
Leg Pain	☐	☐
Cough	☐	☐
Wheezing	☐	☐

Social History

Occupation:

Number of Alcohol Drinks/Week:

Recreational Drugs:

Number of Caffeinated Drinks/Day:

Any Walking Aids Used?

If Chest Pain:

- When did chest pain start? Days? Months? _____
- Where does your chest hurt? _____
- Does your chest pain hurt with rest or activity? _____
- What does the chest pain feel like? _____
- How long does it last? Seconds/ minutes? _____
- What makes it worse? _____
  [ ] Exertion [ ] Food [ ] Position [ ] Palpation [ ]Stress
- What makes it better? _____
  [ ] Rest [ ] Food [ ] Medications
- Any Weight Gain/ Loss? How much? _____