Name:

Primary Care Provider:

PLEASE CHECK IF **YOU** HAVE A PERSONAL HISTORY OF THE FOLLOWING

	Date	Detail		Date	Detail
☐ Heart Attack			☐ Thyroid problems		
☐ High Blood Pressure			☐ Kidney problems		
☐ High Cholesterol			☐ Lung problems		
☐ Diabetes			☐ Liver problems		
☐ Stroke			☐ Valve disease		
☐ Atrial fibrillation			☐ Sleep Apnea		
☐ Heart arrhythmias			☐ Other		

PLEASE CHECK IF **YOU** HAVE HAD ANY OF THE FOLLOWING CARDIAC PROCEDURES/TESTS

	Date	Detail		Date	Detail
☐ Bypass Surgery			☐ Stent		
☐ Heart Cath			☐ Pacemaker		
☐ Stress test			☐ Defibrillator		
☐ A-fib ablation			☐ SVT ablation		

PLEASE CHECK IF **YOU** HAVE HAD ANY OF THE FOLLOWING PROCEDURES:

	Date	Detail		Date	Detail
☐ Gallbladder surgery			☐ Hip replacement		
☐ Appendectomy			☐ Back surgery		
☐ Cataract surgery			☐ Rotator cuff repair		
☐ Knee arthroscopy			☐ Carpal tunnel		
☐ Knee replacement			☐		
☐			☐		
☐			☐		

PLEASE CHECK IF ANY FIRST DEGREE RELATIVES (PARENTS, SIBLINGS, CHILDREN) HAVE HAD:

	Age	Detail		Age	Detail
☐ Heart Attack			☐ Diabetes		
☐ Stent			☐ Cancer		
☐ Bypass Surgery			☐ Sudden Death		
☐ High Blood Pressure			☐ Atrial fibrillation		
☐ Stroke			☐ Valve disease		

PLEASE CHECK ANY OF THE FOLLOWING YOU EXPERIENCE REGULARLY

☐ fevers	☐ shortness of breath	☐ muscle weakness
☐ chills	☐ wheezing	☐ TIA (mini stroke)
☐ night sweats	☐ nausea	☐ stroke
☐ insomnia	☐ vomiting	☐ difficulty concentrating
☐ impaired eyesight	☐ diarrhea	☐ speech difficulty
☐ loss of peripheral vision	☐ blood in the stool	☐ muscle aches
☐ vertigo (spinning sensation)	☐ black tarry stools	☐ significant weight gain
☐ ringing in the ears	☐ urinary frequency	☐ unintended weight loss
☐ palpitatons	☐ frequent nighttime urination	☐ anxiety
☐ syncope (passing out)	☐ blood in the urine	☐ depression
☐ edema (leg swelling)	☐ rash	☐ easy bruising
	☐ nail changes	☐ purple skin discoloration

MEDICATIONS

Medication name	Dosage	Frequency

ALLERGIES

Medication/Allergen	Reaction

LIFESTYLE ISSUES

HABITS

Do you smoke or use tobacco products?	Yes No - Quit Never	____ packs/day ____ years ago
Do you drink alcoholic beverages?	Yes No	____ drinks per day/week/month
Do you use drugs such as cocaine, marijuana, heroin, ecstasy, prescription narcotics, etc?	Yes No - Quit No	 ____ years ago
Do you drink caffeinated beverages?	Yes No	____ drinks per day
Do you consume energy drinks, for example Red Bull, Monster, 5 hour Energy	Yes No	

WHICH OF THE FOLLOWING DESCRIBES YOUR DIET (you may check more than one)

☐ Low Fat Diet	☐ Diabetic diet
☐ Low Salt Diet	☐ I sometimes "cheat" on my diet
☐ No particular diet	☐ Vegetarian diet
☐ Vegan diet	☐ Mediterranean diet
☐ I have a weakness for: sweets / ice cream / cookies / cheese /salty snacks	

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR EXERCISE HABITS

☐ I am unable to exercise regularly
☐ I do not exercise regularly
☐ I rarely exercise - 2 or fewer days a week on average
☐ I exercise regularly - 3 or more days a week
What do you do for exercise: