Sunnyvale Cardiology Associates

Today's Date: _____/_____/_____

Patient Name: _____ DOB: ____/____/_____ Age: ____ Gender: ☐ Male ☐ Female

Occupation: _____ Referring Physician: _____

Pharmacies:

1. Phone Number_____ Location: _____
2. Phone Number_____ Location: _____

Reasons for your visit today:

☐ Pre Surgical Evaluation
☐ Screening Cardiac Evaluation
☐ Establish New Cardiologist
☐ Abnormal Rhythm
☐ Chest Pain
☐ Dizziness
☐ Fainting/Syncope
☐ Heart Failure
☐ Heart Murmur
☐ Hypertension
☐ Palpitations
☐ Shortness of Breath
☐ Swollen Legs
☐ Other: _____

Post Op:
☐ Heart Cath
☐ Device Implant Check
Type
☐ Boston Scientific
☐ Medtronic
☐ St. Jude
Who implanted the device?
_____

For MA Only

B/P_____

Pulse_____

WT_____

HT_____

Prior Heart Disease and/or Procedures/Surgeries and/or Testing (Please check Yes or No to all choices)

		If Yes, What Year	Location	How Many
Heart Murmur	☐ Yes ☐ No	_____		
Valve Prolapse	☐ Yes ☐ No	_____		
Rheumatic /Scarlet Fever	☐ Yes ☐ No	_____		
Congestive Heart Failure	☐ Yes ☐ No	_____		
Heart Failure	☐ Yes ☐ No	_____		
Heart Cath	☐ Yes ☐ No	_____	_____	
Angioplasty	☐ Yes ☐ No	_____	_____	
Stent	☐ Yes ☐ No	_____	_____	_____
By Pass Surgery	☐ Yes ☐ No	_____	_____	_____
Pacemaker	☐ Yes ☐ No	_____	_____	
Defibrillator (ACID)	☐ Yes ☐ No	_____	_____	
Echo ultrasound	☐ Yes ☐ No	_____	_____	
Carotid ultrasound	☐ Yes ☐ No	_____	_____	
Treadmill Stress Test	☐ Yes ☐ No	_____	_____	
Holter (24 hour)	☐ Yes ☐ No	_____	_____	

Which of the following risk factors do you have?

		If Yes, What Year	
High cholesterol	☐ Yes ☐ No	_____	
High blood pressure	☐ Yes ☐ No	_____	
Diabetes	☐ Yes ☐ No	_____	☐ Type 1 ☐ Type 2
Currently Pregnant	☐ Yes ☐ No	_____	what trimester _____
Female Menopause	☐ Yes ☐ No	_____	Hormones ☐ Yes ☐ No If yes, what are you taking_____
Current Smoker	☐ Yes ☐ No	_____	if yes, how many packs daily? _____

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Blood Vessel Diseases

		If Yes, What Year
Carotid disease or endarterectomy	☐ Yes ☐ No	_____
Stroke or TIA (ministroke)	☐ Yes ☐ No	_____
Aortic aneurysm	☐ Yes ☐ No	_____
Poor leg circulation	☐ Yes ☐ No	_____
Leg cramps while walking	☐ Yes ☐ No	_____
Venous thrombosis (leg clots)	☐ Yes ☐ No	_____
Pulmonary embolism (lung clots)	☐ Yes ☐ No	_____

List all Current Prescription and Non-Prescription Medications you are taking:

Name	Dose/Strength	Frequency
Example: Lasix	*40 mg*	*2 in the AM/1 in the PM*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Drug Allergies

Name	Reaction
Example: Lasix	*Hives*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all Surgeries/Operation

Name	Year	Location
Example: Appendectomy	*1995*	*Texas Regional Medical Center*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Review of Conditions that you currently have:

General

☐ Cancer

List site(s) _____

Endocrine

☐ Low Thyroid

Eyes

☐ Glaucoma

☐ Cataracts

Lung/Breathing

☐ Asthma

☐ Persistent Cough

☐ Bronchitis

☐ Emphysema

Abdomen

☐ Hiatus hernia

☐ Heartburn

Kidney/Bladder

☐ Dialysis

☐ Kidney stones

Infections

☐ AIDS/HIV

Blood

☐ Bleeding Problems

☐ Leukemia

Neurological

☐ Seizures/Epilepsy

Social History

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

How many hour per week do you spend active? _____ Hours per week

Do you consume alcoholic drinks? ☐ Never ☐ I did, but I quit in _____ (year) ☐ Yes, I consume _____drinks weekly

Do you consume caffeine? ☐ Yes ☐ No

If yes, please check all types that you consume:

☐ Coffee ☐ tea ☐ soda ☐ chocolate ☐ energy drinks

Do you use tobacco? ☐ Yes ☐ No

If yes, please check all types that you use:

☐ Cigarettes ☐ cigars ☐ pipes ☐ chewing tobacco

Do you use vapor or electronic cigarette devices? ☐ Yes ☐ No If yes, please check which one: ☐ vapor ☐ electronic

Family History

Relation	Living	Age	Condition (Heart Attack, Diabetes, Hypertension, etc	Cause of Death
Father				
Mother				
Brother				
Sister				
Other				

I have reviewed the above information with the patient on ____/____/_____,

Signature of Reviewer:_____