West Side Cardiology Associates, Inc.

NAME:______________________________________ APPOINTMENT'S DATE: __________________

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

1.What is the reason for your visit? ____

2. How long have you had this problem? ____

3. Please list your preferred local pharmacy (Name,Street,City)____________________________________
Name of preferred mail-in pharmacy____

PAST MEDICAL HISTORY (Please Check any illness you have had)

___ Abdominal Aortic Aneurysm
___ Abnormal Cholesterol
___ Abnormal Echocardiogram
___ Abnormal EKG
___ Abnormal Stress Test
___ Angina
___ Aortic Valve Disease
___ Atrial Fibrillation
___ Atrial Flutter
___ Cardiomyopathy
___ Carotid Stenosis (narrowing) w/stroke
___ Carotid Stenosis (narrowing) w/o stroke
___ Chest Pain
___ Claudication
___ COPD
___ Coronary Artery Disease
___ Coumadin/Warfarin Use
___ Diabetes
___ Dizziness or Lightheadedness
___ DVT (Blood clot in leg vein)
___ Edema (Swelling in legs)
___ Heart Failure
___ Heart Murmur
___ Heart Rhythm Disorder
___ History of Heart Attack
___ Hypertension (High Blood Pressure)
___ICD(Defibrillator)
___Kidney Disease
___Left Bundle Branch Block
___MitralValve Disease
___Pacemaker
___Palpitations
___Pulmonary HTN
___Right Bundle Branch Block
___Shortness of Breath
___Sleep Apnea
___Stroke
___Syncope(Loss of conscience)
___T.I.A.(mini stroke)

___ Other ____

PAST SURGICAL HISTORY

Cardiovascular Surgeries	Date and Hospital
___ Ablation	______________________________
___ Aneurysm Repair	______________________________
___ Angioplasty/Stent	______________________________
___ CABG/Bypass	______________________________
___ Carotid Surgery	______________________________
___ ICD/Pacemaker	______________________________
___ IVC Filter	______________________________
___ Valve Surgery	______________________________
___ Other Cardiovascular Surgery	______________________________

Other Surgeries

___ Appendectomy
___ Hysterectomy
___ Cataract
___ Joint Replacement
___ Gallbladder
___ Tonsillectomy
___ Other Surgeries ____

MEDICATIONS (Please attach a list of all medications and doses)

ALLERGIES (List the medications you are allergic to)

Allergies: ____

____

FAMILY HISTORY (Please check any illness and how related)

	Father	Mother	Brother	Sister
___ Abdominal Aneurysm	___	___	___	___
___ Abnormal Cholesterol	___	___	___	___
___ Coronary Artery Disease	___	___	___	___
___ Diabetes	___	___	___	___
___ Heart Failure	___	___	___	___
___ History of Heart Attack	___	___	___	___
___ Hypertension (High Blood Pressure)	___	___	___	___
___ ICD (Defibrillator)	___	___	___	___
___ Pacemaker	___	___	___	___
___ Stroke	___	___	___	___
___ Syncope (Loss of consciousness)	___	___	___	___

SOCIAL HISTORY

Occupation____

Tobacco Use : ___Current Everyday ___Current Some ___Former ___Never
If former tobacco user: Age started __________ Age Stopped ___________ How many Packs per day ________

Alcohol Use: ___Current Everyday ___Current Some ___Former ___Never

______Please check this box if you would like to speak with your doctor about current or former drug use.

REVIEW OF SYSTEMS (Please check ALL symptoms you have had either NOW or in the past)

CONSTITUTIONAL: ___ Fever ___ Chills ___ Night Sweats

EYES: ___ Blurred vision ___Abrupt Change of Vision

HENT: ___ Difficulty Swallowing ___ Nose Bleeds

CARDIOVASCULAR: ___ Chest Pain ___ Palpitations ___ Lightheadedness
___ Loss of Consciousness ___ Leg Swelling ___ Awakening at Night Short of Breath
___ Difficulty Sleeping Flat due To Shortness of Breath

RESPIRATORY: ___ Cough ___ Wheezing ___ Shortness of Breath

GASTROINTESTINAL: ___ Nausea ___ Vomitting ___ Diarrhea
___ Constipation ___ Blood in Stools

GENITOURINARY: ___ Painful Urination ___ Blood in Urine

NEUROLOGICAL: ___ Loss of Balance ___ Seizures

MUSCULOSKELETAL: ___ Difficulty Walking ___ Joint Pain

ENDOCRINE: ___ Diabetes ___ Thyroid Disease

HEME/ONC: ___ Easy Bleeding ___ Easy Bruising