SUN STATE CARDIOLOGY
1100 S. DOBSON ROAD, STE. 118
CHANDLER, ARIZONA 85286
(480) 821-3800 FAX: (480) 821-3806

PATIENT MEDICAL HISTORY

Welcome to Sun State cardiology

Please complete the following questionnaire so that our physicians may best assess your needs.

Name:	Date:
Referring Physician:	Preferred Hospital:
Preferred Pharmacy:	Pharmacy Phone:

Reason for today's visit (symptoms):

1. Have you had CHEST DISCOMFORT? ☐ Yes ☐ No, If yes, please answer details below:

Describe the discomfort: ☐ Sharp ☐ Dull

How often does it occur: ☐ Daily ☐ Weekly ☐ Monthly

What precipitates or aggravates the discomfort? _____

Does it radiate to your ARM, BACK or NECK? ☐ Yes ☐ No

Do you ever sweat during this discomfort? ☐ Yes ☐ No

Do you ever become nauseated? ☐ Yes ☐ No

Does it happen when you exert yourself? ☐ Yes ☐ No

Does it happen when you are under stress? ☐ Yes ☐ No

Does nitroglycerin help to ease the discomfort? ☐ Yes ☐ No

If YES, how many minutes does it take before medication eases the discomfort? _____

2. Have you ever had a heart attack? ☐ Yes ☐ No, If yes, please answer details below:

a) Date: _____

b) Name of Physician: _____

c) Name of Hospital: _____

3. Have you ever had coronary bypass surgery or any other type of heart surgery?	☐ Yes ☐ No	If yes, please answer 3a-c

a. Date of surgery:_____

b. Name of Surgeon:_____

c. Name of Hospital:_____

4. Please list the most vigorous activity that you perform (i.e., walking, housework, running, etc.) and what, if anything, limits that activity (chest pain, shortness of breath, leg pain, fatigue, etc.):

5. If you have had one of the following procedures, please list the date, place and physician involved:

Procedure	Date	Place	Physician
CARDIAC CATHETERIZATION (a dye study of the arteries of the heart sometimes referred to as an ANGIOGRAM)			
CORONARY ANGIOPLASTY (Balloon)			
ECHOCARDIOGRAM (ultrasound of the heart)			
CHEMICAL OR TEADMILL STRESS TEST			
Chest x-ray			
EKG			

6. Please list any chronic medical problems (diabetes, high blood pressure, etc.)

7. Please list your past surgeries, including date, hospital and name of surgeon. If you don't recall the exact date, please provide the year.

Surgery	Date	Place	Surgeon

8. Please list all current medications you are taking, including dosage and frequency.

Medication Name	Dosage	Frequency

9. Are you allergic to any medications or foods? ☐ NO ☐ YES

If YES, please list medication and state what type of reaction you had

_____

10. Have you ever had a reaction to: ☐ INTRAVENOUS DYE ☐ SHELLFISH ☐ IODINE

If YES, please list the details _____

11. Does anyone in your family have a cardiac problem? ☐ YES ☐ NO

If YES, please list their relationship to you, age of onset and their current health:

RELATIONSHIP	AGE OF ONSET	CURRENT HEALTH

PERSONAL INFORMATION

Birthplace:	Employment:
Marital Status:	Number of children:
Do you smoke: ☐ YES ☐ NO If previously, when did you quit? _____	Do you drink alcohol? ☐ YES ☐ NO If YES, how many drinks? ____ How often a week? _____
Please list your hobbies:	

DO YOU HAVE OR HAVE YOU EVER HAD (please mark YES or NO):		
High Blood Pressure?	☐YES	☐NO
Heart failure or heart enlargement?	☐YES	☐NO
Irregular heartbeat or palpitations?	☐YES	☐NO
Shortness of breath when resting?	☐YES	☐NO
Shortness of breath with exertion?	☐YES	☐NO
Trouble breathing when you lie down flat? If YES, how may pillows you use to sleep?	☐YES	☐NO
Waking up at night with shortness of breath?	☐YES	☐NO
Swelling of the feet or ankles?	☐YES	☐NO
Recent weight gain from fluid retention?	☐YES	☐NO
Fainting spells?	☐YES	☐NO
Stroke or near stroke?	☐YES	☐NO
Pain in your legs when you walk?	☐YES	☐NO
High Cholesterol?	☐YES	☐NO
Diabetes?	☐YES	☐NO
Inflammation of the sack around the heart?	☐YES	☐NO
Valvular heart disease?	☐YES	☐NO
Rheumatic fever as a child?	☐YES	☐NO
Peptic ulcer disease?	☐YES	☐NO
Blood in your stool?	☐YES	☐NO
Tendency to bleed easily?	☐YES	☐NO
Hiatal hernia?	☐YES	☐NO
Have you ever vomited blood?	☐YES	☐NO
Hepatitis?	☐YES	☐NO
Any kind of cancer?	☐YES	☐NO
Any type of IV drug use?	☐YES	☐NO
Asthma or Emphysema?	☐YES	☐NO
Kidney Failure?	☐YES	☐NO
Blood clots in legs or lungs?	☐YES	☐NO
Please list any other symptoms below that you feel apply, but are not listed above:		