MEMORIAL KATY
CARDIOLOGY ASSOCIATES

Name: ____ **DOB:** ____/____/_____ **Today's Date:** ____/____/_____
Cell or Home Phone Number: (____) ____-_____ **Email:** ____

What is the main reason for your visit? (i.e. check up) ____

Were you referred by another doctor? **Yes** **No** **If yes, who?** ______________________________

Do you have a primary care doctor? Who? ______________________________ or **None**

Who, if any, are the specialists you see? ____

How did you hear about us? (Circle one) **Physician Referral, Friend/Relative, Internet Search**
Other: ____

Recent Symptoms

1.	**Do you have chest pain?**	**Yes**	**No**
2.	**Do you have shortness of breath?**	**Yes**	**No**
	a. If yes, with exertion?	**Yes**	**No**
	b. If yes, while lying flat in bed?	**Yes**	**No**
	c. If yes, does it wake you at night?	**Yes**	**No**
3.	**Have you had swelling in your legs?**	**Yes**	**No**
4.	**Do you routinely develop pain in your legs when you walk?**	**Yes**	**No**
5.	**Have you passed out recently?**	**Yes**	**No**
6.	**Have you felt your heart beating fast or skipping for no reason?**	**Yes**	**No**

Past Medical History

	Problem	**Year Diagnosed**
1.		
2.		
3.		

High Blood Pressure	**Yes**	**No**
High Cholesterol	**Yes**	**No**
Diabetes	**Yes**	**No**
Heart Attack	**Yes**	**No**
Heart Failure	**Yes**	**No**

Past Surgical History

	Type of Surgery	**Year of Surgery**
1.		
2.		
3.		

Family Medical History

Do heart attacks run in your family? **Yes** **No**

If so, who, and at what age did they have it?

____

Please list any health concerns (especially cardiac) of your:
Father: (Alive or Deceased?) ____
Mother: (Alive or Deceased?) ____
Paternal Grandparents: (Alive or Deceased?) ______________________________
Maternal Grandparents: (Alive or Deceased?) ______________________________
Siblings: (Alive or Deceased?) ____ →

(CONTINUED ON THE BACK)

Social History

1. Do you currently smoke? Yes No Never Number of packs per day: _________
   - If no, how long ago did you quit? _______________

2. Do you exercise routinely? Yes No Type: ___________________________________
3. Do you currently drink caffeine? Yes No Number of drinks per day: _________
4. Do you currently drink alcohol? Yes No Number of drinks per day: _________
5. Occupation: ______________________
   - Or, circle one: Retired Unemployed Disabled

Please list your current medications below (or write 'none' if appropriate):

Name	Dose	Frequency
•		
•		
•		
•		
•		
•		
•		
•		
•		

Please list any medication allergies below (or write 'none' if appropriate):

-
-
-

What Pharmacy do you use? Please provide address and phone number if known:

____

Review of Recent Symptoms: Circle all that apply or circle "None"

Constitutional: None

Fevers

Endocrine: None

Fatigue

Gastrointestinal: None

Abdominal Pain
Black (tar colored) stool

Musculoskeletal: None

Muscle aches

Neurology: None

Weakness in arms or legs
Visual Changes

Psychiatric: None

Depression

Genitourinary: None

Lack of sexual function (impotence)