Clarkson Heart
CENTER

ALLERGIES:

Are you allergic to contrast dye? YES NO

If yes, what is your reaction? _____

Do you have any medication allergies? YES NO

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

PHARMACY:

Which pharmacy do you use? _____

Intersection/Location:_____

Mail-in pharmacy: _____

SURGERIES:

Have you had any surgical procedures? Please list below.

Type **Date**

_____

_____

_____

_____

_____

_____

_____

STRESS TESTING:

Have you had a stress test in the last 3 years? YES NO

If yes, where? _____

ECHOCARDIOGRAM/ULTRASOUND:

Have you had an echocardiogram in the last 2 years? YES NO

If yes, where? _____

HEART MONITOR:

Have you worn a heart monitor in the last 6 months? YES NO

If yes, where? _____

HOSPITALIZATIONS:

Have you been hospitalized for a cardiac condition in the last year?

YES NO

If yes, which hospital and why

_____

_____

_____

_____

_____

NOTES:

Clarkson Heart CENTER

PATIENT NAME: _____ **AGE:** _____

PRIMARY CARE PROVIDER: _____

REASON FOR VISIT: _____

IS THIS FOR CARDIAC CLEARANCE FOR SURGERY? YES NO

IF YES, WHO IS THE SURGEON? _____

CARDIAC HISTORY:

Have you ever had a heart catheterization? YES NO
If yes, when: _____
Have you ever had a stent or bypass surgery? YES NO
If yes, when: _____
Have you ever had a heart attack? YES NO
If yes, when: _____
Do you have heart failure? YES NO
If yes, do you know your EF: _____%
Do you have a pacemaker or defibrillator? YES NO
If yes, which type: Medtronic St Jude Biotronik Other
Have you ever had a heart valve replacement? YES NO
If yes, when: _____ Which valve: _____
Have you been experiencing chest pain, pressure, tightness, heaviness? YES NO
Have you been experiencing shortness of breath at rest or with activity? YES NO
Do you wake up gasping for air? YES NO
Do you need multiple pillows to sleep? YES NO
Do you have any lower leg swelling? YES NO
Do you feel your heart flutter, skip beats or race? YES NO
Have you had recent passing out/fainting? YES NO
Do you have lightheadedness/dizziness? YES NO

VASCULAR HISTORY:

Have you ever had stents placed in your legs? YES NO
Have you ever had a blood clot in your legs/lungs? YES NO
Pain in your calves/thighs/buttocks when walking? YES NO

CARDIOVASCULAR RISK FACTORS:

Have you smoked/vaped or chewed tobacco? YES NO
Packs/day_____ Cans/week_____ Years _____ Year quit_____
Would you like help to quit smoking? YES NO
Do you have high blood pressure? YES NO
Do you have high cholesterol? YES NO
Are you diabetic? If yes, how long_____ YES NO

Is there a family history of:

Coronary artery disease (heart attack, bypass, stents) YES NO
If yes, who_____
Heart failure? If yes, who_____YES NO

HABITS/SOCIAL HISTORY:

Do you use caffeine? How much? _____ YES NO
Do you use alcohol? How much? _____ YES NO
History of drug use? What drugs?_____YES NO
Current occupation: _____
Marital status: _____ # of children:_____

REVIEW OF SYSTEMS: (PLEASE CIRCLE):

A-GENERAL

Have you had recent fever, chills or sweats? YES NO

B-EYES

Have you been experiencing vision changes? YES NO
If yes, explain. _____
Do you wear glasses/contacts? YES NO

C-THROAT, MOUTH AND EARS

Do you have difficulty swallowing? YES NO
Are you hard of hearing? YES NO

D-RESPIRATORY

Do you have asthma or COPD? YES NO
Do you have sleep apnea? YES NO
If yes, do you wear a CPAP or BiPAP? YES NO
Have you been experiencing a cough? YES NO

E-GASTROINTESTINAL

Do you have acid reflux? YES NO
Do you have stomach ulcers? YES NO
Do you have nausea/vomiting? YES NO
Do you have abdominal pain? YES NO

F-GENITO-URINARY TRACT

Have you ever had kidney stones? YES NO
Do you have painful urination? YES NO
Do you have a history of kidney failure? YES NO

G-MUSCULOSKELETAL

Do you have arthritis? YES NO
Are you able to walk unassisted? YES NO

H-ENDOCRINE

Do you have thyroid disease? YES NO

I-HEMATOLOGY

Do you have cancer? Where? _____ YES NO
Do you have anemia? YES NO
Do you take a blood thinner? _____ YES NO

J-NEUROLOGIC

Have you ever had a stroke? YES NO
Do you have a seizure disorder? YES NO
Have you been having weakness? YES NO

K-PSYCHIATRIC

Do you have a history of anxiety? YES NO
Do you have a history of depression? YES NO
Do you have a history of mental illness? YES NO

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