Confidential Patient Information

Name ________________________________ Date __________________________

Sex M☐ F☐ Other☐ Date of Birth _____________________ Height _______Weight _________

Phone ________________________________ Email ____

Address ______________________________ City ___________________________ Postal Code ________

Family Physician __________________________________ Referring Doctor _________________________

Health Card Number ______________________________ Version Code ____________________________

Who may we thank for referring you to our office? ____

Your Health Profile

☐Enlarged Heart
☐Chest Pains, Pressure or Heaviness
☐Arm or Shoulder Pains or Heaviness
☐Neck, Jaw, Throat Discomfort
☐Shortness of Breath
☐Dizziness or Light-headedness
☐Swollen Feet
☐Swollen Ankles or Calves
☐Heart Failure
☐Blue Lips or Fingernails
☐Leg Cramps at Rest

☐Heart attack
☐Angina
☐High Blood Pressure
☐High Cholesterol
☐Diabetes
☐Heart Murmur
☐Rheumatic Fever
☐Abnormal Heart Rhythm (Arrhythmia)
☐Palpitations or Irregular Heartbeat
☐Fainting

Please list any **Allergies** ____
Please list your Reactions ____

Please list any medications including nonprescription drugs, supplements and any herbal or naturopathic products. Please include dose or strength and number of times a day.

____
____
____

Family History

Does anyone in your family have a history of (Please Check applicable box & explain) :

☐ Heart disease (stents/heart attacks) Relationship/Age of diagnosis

____

☐ Heart surgery Relationship/Age of diagnosis

____

☐Hypertension Relationship/Age of diagnosis

____

☐ Diabetes mellitus Relationship/Age of diagnosis

____

☐Stroke Relationship/Age of diagnosis

____

☐Vascular problems Relationship/Age of diagnosis

____

Cardiac History

☐Stress Test; When ____________________
☐ECHO Test; When ____________________
☐Heart Catheterization; When ____________________
☐Coronary Angioplasty; When ____________________
☐Stent/Other Coronary Therapy; When ____________________
☐Coronary Bypass Surgery; When ____________________
☐Valve Surgery; When ____________________
☐Electrophysiology Study; When ____________________
☐Pacemaker or Defibrillator; When ____________________

Symptoms

Please check any symptoms that you are experiencing from the following list:

☐Fatigue
☐Fever
☐Chills
☐Unintentional Weight loss or Weight Gain
☐Wheezing
☐Cough
☐Asthma
☐Heartburn
☐Indigestion
☐Nausea
☐Ulcers
☐Diahrrhea
☐Constipation
☐Tarry Stool
☐Joint Pains

Other ____

☐Muscle Ache
☐Muscle Tenderness
☐Ulcers of the skin
☐Rash Itching
☐Temporary Paralysis
☐Permanent Paralysis
☐Weakness
☐Stroke
☐Numbness
☐Excessive Thirst
☐Excessive Urination
☐Bleeding
☐Easy Bruising
☐Anemia
☐Cancer