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