# BALTIMORE HEART ASSOCIATES

**Name:** | **DOB:** | **Age:** | **Requesting/Primary Physician:**

Please help us find out about you by filling out this form. If you don't know the answer to one of the questions, ask your bed partner, he/she may be able to answer it for you.

**Why are you here to see the cardiologist (heart doctor)?**

_____

_____

_____

**Check off any heart problems or symptoms**

- ❒ Heart attack
- ❒ Angina
- ❒ High blood pressure
- ❒ Low Blood Pressure
- ❒ Heart murmur
- ❒ Abnormal rhythm (arrhythmia)
- ❒ Palpitations/irregular heart beats
- ❒ Fainting
- ❒ Leg cramps when you walk
- ❒ Enlarged heart
- ❒ Chest pains or pressure
- ❒ Shortness of breath
- ❒ Dizziness
- ❒ Swollen legs
- ❒ Heart failure
- ❒ Blue lips or fingernails
- ❒ Stroke

**Have you ever had:**

- ❒ A stress test
- ❒ An Echocardiogram
- ❒ Cardiac Catheterization/Heart Catheterization
- ❒ Coronary Angioplasty (balloon/atherectomy/stent)
- ❒ Coronary Bypass Surgery
- ❒ Valve Surgery
- ❒ An Electrophysiology Study or Procedure
- ❒ A Pacemaker or Defibrillator

**Tell us about your risk of heart disease**
**Please check if you have:**

- ❒ High blood pressure
- ❒ High cholesterol
- ❒ Ever smoked
- ❒ Diabetes

**Please tell us anything else about your heart:**

_____

_____

**If you are a woman, have you passed menopause** (change of life)? ❒ No

❒ Yes At what age? _____

Do you take estrogen? _____

**Have you had the following vaccinations?**

- ❒ Influenza ("Flu Shot") Annually
- ❒ Pneumococcal ("Pneumonia") Vaccine

**Are you being treated now or have you been treated for any illnesses? Please list them.**

1 _____
2 _____
3 _____
4 _____
5 _____

**Have you ever had any operations? Hospitalizations? Injuries?**

1 _____
2 _____
3 _____
4 _____
5 _____

**Health Habits:**

Do you smoke? ❒ No ❒ Yes

How many packs per day? _____

How many years? _____

How much alcohol do you drink? _____

Do you use any recreational drugs? ❒ No

❒ Yes List: _____

Do you use caffeine? ❒ No ❒ Yes

Do you exercise (include walking)? ❒ No ❒ Yes

**Family/ Social History:**

Marital Status: **S M W D**

With whom do you live? _____

Occupation: _____

Leisure Activities: _____

**Check if any close family members (parents, brothers, sisters, children have:**

- ❒ Heart problems
- ❒ High blood pressure
- ❒ Diabetes
- ❒ Cancer

**Has a close family member had a heart attack, angina, or bypass surgery?** ❒ No ❒ Yes

If yes, who? _____

Are there any other health problems in your family?

_____

_____

_____

_____

**Please circle any symptoms you have, so that we can find out more about it:**

Lack of energy; daytime sleepiness; trouble sleeping; snoring; loss of appetite; weight changes; fevers

Eye problems, ex: double or blurred vision; glaucoma; cataracts
Hearing problems; buzzing or ringing in ears

Allergies; hay fever

Sinus problems

Asthma; tuberculosis

Stomach problems; heartburn; indigestion; change in bowl habits
Bloody/tarry stools; jaundice; liver problems; ulcers; gallstones
Urinary problems: Frequency; infections; stones; bladder

Men: Prostate problems; night-time urination
Women: Abnormal menstrual periods; pregnancy
Joint pains swelling or redness; arthritis; back pain

Muscle aches or tenderness; gout

Rash, itching or other skin problems

Paralysis (even temporary); stroke; numbness; loss of

Seizures; loss of memory; headaches

Unusual thoughts; nervousness; crying or sadness;

Thyroid disorder; diabetes; excess thirst, hunger or

Bleeding; easy bruising; risk factors for HIV;

**Notes:**

_____

_____

**Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications:**

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____

**Are you allergic to any medications? ❒ No ❒ Yes- If yes, please list medications to which you are allergic & reactions:**

1 _____
2 _____
3 _____
4 _____

**Do you have hay fever?** ❒ No ❒ Yes - What is your reaction:

_____

_____