



ASSOCIATES IN CARDIOVASCULAR DISEASE

PATIENT NAME: _____ DATE OF BIRTH: _____ AICD PHYSICIAN: _____
 TODAYS DATE: _____ DATE OF YOUR NEXT VISIT: _____
 PRIMARY CARE PHYSICIAN: _____ PATIENT E MAIL: _____ PHONE: _____ CELL #: _____
 EMERGENCY CONTACT NAME AND PHONE: _____
 PHARMACY NAME/TOWN: _____ MAIL AWAY PHARMACY: _____
 REASON FOR YOUR VISIT : _____ WHO REFERRED YOU TO US? _____

RISKS:
Tobacco
 ___ Y ___ N ___ Former
 ___ Packs/day
 ___ Year quit

High Cholesterol
 ___ Y ___ N ___ Unknown

Diabetes
 ___ Y ___ N
 ___ Year Diagnosed

High Blood Pressure
 ___ Y ___ N ___ Unknown
 ___ Year Diagnosed

Family History of Heart Disease
 ___ Y ___ N ___ Unknown

SOCIAL HISTORY
Marital status:
 ___ M ___ D ___ S ___ W
 Children ___ Y ___ N ___ #
 Race: _____
 Primary Language: _____

Lifestyle
 Diet:
 ___ Regular
 ___ Low fat, low cholesterol
 ___ Low salt
 ___ Diabetic

Exercise
 ___ Sedentary
 ___ Occasional
 ___ Regular
 ___ Active Lifestyle
 ___ Physically unable

Alcohol
 ___ Y ___ N ___ Former
 ___ Year quit
 ___ Daily ___ Rarely ___ Socially

Caffeine
 ___ None ___ Coffee ___ Tea ___ Soda

YOUR FAMILY HISTORY (Include only the following: Heart disease, diabetes, stroke, cancer)
 (Include parents, siblings)

Family Member	Age of Onset/or age of Death	Pertinent History
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

YOUR MEDICAL HISTORY: List any illnesses you have or are being treated for :
 Include ALL HOSPITALIZATIONS and SURGERIES in the past five years
 Include Reason for admission and/or type of surgery Year

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____

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<u>Have you ever had any of the following tests?</u>			<u>Have you ever had any of the following?</u>		<u>ALLERGIES</u>
	Location	Year		Year	
<input type="checkbox"/> Stress test	_____	_____	<input type="checkbox"/> Diabetic retinopathy	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____	<input type="checkbox"/> Macular degeneration	_____	_____
<input type="checkbox"/> Cardiac catheterization	_____	_____	<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Carotid ultra sound	_____	_____	<input type="checkbox"/> COPD	_____	_____
<input type="checkbox"/> Cardiac Bypass	_____	_____	<input type="checkbox"/> Pulmonary embolism	_____	_____
<input type="checkbox"/> Cardiac Stent/Angioplasty	_____	_____	<input type="checkbox"/> Sleep Apnea	_____	MEDICATIONS (Include over the counter) Medication Dose Frequency _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
<input type="checkbox"/> Implantable Defibrillator	_____	_____	<input type="checkbox"/> Gallbladder Disease	_____	
<input type="checkbox"/> Pacemaker	_____	_____	<input type="checkbox"/> GERD (reflux)	_____	
<u>Have you ever had any of the following?</u>			<input type="checkbox"/> Peptic Ulcer	_____	
		Year	<input type="checkbox"/> GI Bleed	_____	
<input type="checkbox"/> Heart attack		_____	<input type="checkbox"/> Hysterectomy	_____	
<input type="checkbox"/> Shortness of breath		_____	<input type="checkbox"/> Psoriasis	_____	
<input type="checkbox"/> Heart murmur		_____	<input type="checkbox"/> Diabetic neuropathy	_____	
<input type="checkbox"/> Rheumatic fever		_____	<input type="checkbox"/> Migraines	_____	
<input type="checkbox"/> Abnormal heart rhythm		_____	<input type="checkbox"/> Hyperthyroid	_____	
<input type="checkbox"/> Palpitations		_____	<input type="checkbox"/> Hypothyroid	_____	
<input type="checkbox"/> Leg cramps while walking		_____	<input type="checkbox"/> Cancer ; Type _____	_____	
<input type="checkbox"/> Stroke		_____	<input type="checkbox"/> Anemia	_____	
<input type="checkbox"/> TIA (Mini stroke)		_____	<input type="checkbox"/> Easy bruising/bleeding	_____	
<input type="checkbox"/> Enlarged heart		_____	<input type="checkbox"/> Bipolar disorder	_____	
<input type="checkbox"/> Chest pain/pressure		_____	<input type="checkbox"/> Anxiety	_____	
<input type="checkbox"/> Dizziness		_____	<input type="checkbox"/> Depression	_____	
<input type="checkbox"/> Swollen legs		_____			
<input type="checkbox"/> Heart failure		_____			
<input type="checkbox"/> Fainting/nearly fainting		_____			