

Medications (Prescriptions, Aspirin, Over the Counter, Herbal)
Please List With Doses:

Allergies to Medications

Please List:

No Known Medication Allergies

Family History of Heart Disease

List Family Members with Heart Problems:
(Including Those Who Have Passed Away)

Social History

Occupation:

Number of Alcohol Drinks/Week:

Recreational Drugs:

Number of Caffeinated Drinks/Day:

Any Walking Aids Used?

If Chest Pain:

- When did chest pain start? Days? Months? _____

- Where does your chest hurt? _____

- Does your chest pain hurt with rest or activity? _____

- What does the chest pain feel like? _____

- How long does it last? Seconds/ minutes? _____

- What makes it worse? _____
[] Exertion [] Food [] Position [] Palpation [] Stress

- What makes it better? _____
[] Rest [] Food [] Medications

- Any Weight Gain/ Loss? How much? _____

Current Symptoms

	Yes	No
Chest Pain?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath?	<input type="checkbox"/>	<input type="checkbox"/>
Do You Sleep on More Than One Pillow at Night?	<input type="checkbox"/>	<input type="checkbox"/>
Do You Wake Up at Night Feeling Short of Breath? Gasping for Air?	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations/Heart Racing?	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/lightheaded?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Passing Out	<input type="checkbox"/>	<input type="checkbox"/>
Leg Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>