Atlanta Heart Associates, P.C.

Medical History for Cardiology Services

Please Complete and Bring to Your Office Visit

Name:_____ Appointment Date:_____

Date of Birth:_____ Age:_____ Height:_____ Sex: ☐ Male ☐ Female

Reason for Today's Office Visit:_____

_____

Please list all current medications:

Medication	Strength/Frequency	Medication	Strength/Frequency

Pharmacy Name (Local):_____ Tel. Number:_____

Pharmacy Name (Mail Order):_____ Tel. Number:_____

Are you allergic to any medications? If so, list with reaction:_____

Are you allergic to iodine or seafood? ☐Yes ☐ No

Have you ever had a reaction to iodine or IV contrast? ☐Yes ☐ No

Are your pregnant? ☐Yes ☐ No Estimated delivery date:_____

Are you nursing? ☐Yes ☐ No

IN EACH SECTION BELOW PLEASE CIRCLE ALL THAT APPLY CURRENTLY TO YOU

GENERAL			
RECENT WEIGHT LOSS	RECENT WEIGHT GAIN	FEVER	CHILLS
CHANGE IN EXERCISE TOLERANCE			

INTEGUMENTARY		
CHANGE IN HAIR OR NAILS	RASHES	SKIN LESIONS

EYES
BLURRED VISION

EARS, NOSE AND THROAT		
HEARING LOSS	NOSE BLEED	DIFFICULT SPEAKING

RESPIRATORY		
SHORTNESS OF BREATH	COUGH	WHEEZING
COUGHING UP BLOOD	SHORTNESS OF BREATH	WAKING UP WITH SHORTNESS OF

CARDIOVASCULAR	
PALPITATIONS	CHEST PAIN
PERIPHERAL EDEMA	PASSING OUT

IN EACH SECTION BELOW PLEASE CIRCLE ALL THAT APPLY CURRENTLY TO YOU

ABDOMINAL	
ULCER DISEASE	BLACK TARRY STOOLS

MUSCULOSKELETAL	
VENOUS INSUFFIENCY	ARTHRITIC SYMPTOMS
BACK PROBLEMS	VARICOSE VEINS

NEUROLOGICAL		
STROKES	TIA	SEIZURE DISORDER

PSYCHIACTRIC		
DEPRESSION	SUBSTANCE ABUSE	ANXIETY

ENDROCRINE	
DIABETES INSULIN DEPENDENT	DIABETES NON-INSULIN DEPENDENT
HEAT/COLD INTOLERANCE	
HYPERTHYROIDSM	HYPOTHYROIDSM

HEMATOLOGICAL/IMMUNOLOGIC		
FOOD ALLERGIES	SEASONAL ALLERGIES	BLEEDING DISORDERS

PLEASE CIRCLE BELOW ALL THAT APPLY TO YOU

PAST MEDICAL ILLNESS				
AAA	ALZHEIMERS DISEASE	ANEMIA	ARTHRITIS (GENERALIZED)	ASTHMA
BLIND-LEGALLY	BPH	BRUIT CAROTID	CANCER_____	CAROTID ARTERY STENOSIS
CATARACT	CIRRHOSIS	COPD	CVA	DEMENTIA
DEPRESSION	DIABETIC NEUROPATHY	DIABETES-INSULIN DEPENDENT	DIABETES-NON-INSULIN DEPENDENT	DEEP VEIN THROMBOSIS
ERECTILE DYSFUNCTION	GASTRIC ULCER	GERD	GI BLEED	GLAUCOMA
GOUT	HEMODIALYSIS	HYPERKALEMIA	HYPERTHYROIDISM	HYPOKALEMIA
HYPONATREMIA	HYPOTHRYROIDISM	L SPINE DISC DISEASE	OBESITY	OSTEOPOROSIS
PARKINSONS DISEASE	PULMONARY EMBOLUS	RENAL FAILURE	SLEEP APNEA	TIA
VARICOSE VEINS	VERTIGO	INSOMNIA	ANGINA	AORTIC VALVE DISEASE
ARRHYTHMIS-BRADYCARDIA	ATRIAL FIBRILLATION	ATRIAL FLUTTER	ATRIAL SEPTAL DEFCT	AV BLOCK
CORONARY ARTERY DISEASE	CARDIOMYOPATHY	CAROTID ARTERY DISEASE	CONGESTIVE HEART FAILURE	CONGENITAL HEART DISEASE
HYPERLIPIDEMIA	HYPERTENSION	HYPOTENSION	MITRAL VALVE DISEASE	MURMUR (CARDIAC)
PALPITATIONS	PERICARDITIS	PERCARDIAL EFFUSION	RENAL ARTERY STENOSIS	RHEUMATIC HEART DISEASE
MYOCARDIAL INFARCTION			VALVULAR HEART DISEASE	

IN EACH SECTION BELOW PLEASE CIRCLE ALL THAT APPLY TO YOU

PAST HISTORY INFECTIOUS DISEASE			
MUMPS	MEASLES AND CHICKENPOX DURING CHILDHOOD	HIV POSITIVE	HEPATITIS
HERPES-SHINGLES	RHEUMATIC FEVER	SCARLET FEVER	TUBERCULOSIS

PAST HISTORY SURGICAL PROCEDURES

PLEASE LIST WITH DATES:_____

TRAUMA HISTORY

PLEASE LIST WITH DATES:_____

PAST HISTORY CARDIOLOGY PROCEDURES-INVASIVE				
CARDIAC CATH	CORONARY ARTERY BYPASS	CARDIAC ANGIOPLASTY	VALVULAR SURGERY	CARDIAC STENTING

PAST HISTORY CARDIOLOGY PROCEDURES-NONINVASIVE				
EKG	TREADMILL STRESS TEST	CHEST X-RAY	TREADMILL PERSFUSION STUDY	CARDIOVERSION
ECHOCARDIOGRAM	TEE	HOLTER MONITOR	EVENT MONITOR	ABI
CAROTID DOPPLER	ARTERIAL DOPPLER LOWER EXTREMITIES	VENOUS DOPPLER LOWER EXTREMITIES	CT OF CHEST	

PERIPHERAL VASCULAR PROCEDURES

PLEASE LIST WITH DATES:_____

IN EACH SECTION BELOW PLEASE CHECK ✓ALL THAT APPLY TO YOU

Cardiac Risk Factors			
Smoke cigarettes currently How long?_____How much?_____		Previous Heart Disease	
Family History of Heart Disease		History of Obesity	
High Cholesterol		No Regular Exercise	
High Blood Pressure		Reached Menopause	
Diabetes		Take Hormones	

Social History/Other Cardiac Risk Factors			
Drink Alcohol Regularly/Drinks per wk_____		Eat a Special Diet? ☐Yes ☐ No (circle below)	
Drink Alcohol Occasionally/Socially		Low Salt/ Low Cholesterol/ Low Fat/ Diabetic	
No Alcohol			
Smoke Currently/Packs per day _____		Exercise	
Used to Smoke but Quit		Exercise Regularly ☐Yes ☐ No ☐NO regular exercise	
History of or Current Drug Use? What type?_____		If yes how many days per week_____	
Single			
Married		Caffeine Use ☐Yes ☐ No (circle below)	
Divorced		Coffee/Soda/Tea	
Widow/Widower		How Much?_____	

PLEASE CIRCLE BELOW ALL THAT APPLY TO YOU

HEART PROBLEMS	FATHER	MOTHER	CHILD	BROTHER	SISTER
HIGH BLOOD PRESSURE	FATHER	MOTHER	CHILD	BROTHER	SISTER
STROKE	FATHER	MOTHER	CHILD	BROTHER	SISTER
DIABETES	FATHER	MOTHER	CHILD	BROTHER	SISTER
PROBLEMS BLEEDING	FATHER	MOTHER	CHILD	BROTHER	SISTER
KIDNEY PROBLEMS	FATHER	MOTHER	CHILD	BROTHER	SISTER
THYROID DISEASE	FATHER	MOTHER	CHILD	BROTHER	SISTER