CLINICAL INTAKE FORM

Please fill in the blank, circle the appropriate letter, or check the appropriate box.
This information is an important component of your clinical assessment. Collecting this information before your visit will allow more quality time with the physician and also help make your evaluation more complete. Your efforts are very much appreciated. This form will be part of your medical record and, therefore, all the information provided is confidential.

Name: ______________________ Date of Birth: ______________

Age: _____ Sex: **M** **F** Height: ________ Today's Date: ______________

Primary Care Doctor/Provider(s): ______________________________

Why are you here to see the cardiologist?

______________________________ Referred by: ______________

Please check off any of the following that apply to you:

- ☐ Heart attack
- ☐ Angina
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Murmur
- ☐ History of Rheumatic Fever
- ☐ Abnormal Heart Rhythm (arrhythmia)
- ☐ Palpitations or Irregular Heartbeats
- ☐ Fainting
- ☐ Enlarged Heart
- ☐ Chest Pain, Pressure or Heaviness
- ☐ Arm or Shoulder Pain or Heaviness
- ☐ Neck, Jaw or Throat Discomfort
- ☐ Shortness of Breath
- ☐ Dizziness or Light-headedness
- ☐ Swollen Calves or Ankles
- ☐ Heart Failure
- ☐ Blue Lips or Fingernails
- ☐ Leg Pain While Walking

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Name: ______________________________ Today's Date: ____________

Cardiac Procedure History: Have you ever had any of the following?

- ☐ Stress Test
- ☐ Heart Ultrasound (Echo); 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 _________

Medical History

Please specify any other illnesses or medical conditions you have now or have had in the past:

Please list any operations or injuries:

If you are a woman, have you passed menopause? **Y N**

At what age? _____

Do you take estrogen replacement? **Y N**

Are you taking birth control pills? **Y N**

Family History:

Family history of coronary disease, angina, heart attack,

or cardiac arrest: **Y N**

If yes, then brothers, sons, or father before age 55: **Y N**

sisters, daughters, or mother before age 65: **Y N**

☐ Other heart problems; Who ______________

Please give age and cause of death, if known, for:

Mother: ____________________________

Father: ____________________________

Brothers/Sisters: _______________________

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Name: ______________________________ Today's Date: ____________

Social History:

Marital Status: **S M W D**

Occupation: ______________________

Retired: **Y N**

Leisure Activities: __________________

Education Level: __________________

Health Habits:

Do you exercise (including walking)? **Y N**

What/how often: ______________________________

History of Tobacco Use: **Y N**

How many years? _____ How much? ______ average packs per day

☐ cigarettes; ☐ cigars; ☐ pipe; ☐ chew

Quit date (if applicable) ____________

Current Tobacco Use: Packs per day _______

History of heavy alcohol use: **Y N**

Current alcohol consumption ___________________

Current coffee consumption ____________________

Any recreational drug use ______________________

Allergies:

Are you allergic to any medications: **Y N**

Please list any medications you can't tolerate and what happens when you take them:

Medications:

Please list your medications *including nonprescription drugs, supplements, and any herbal or naturopathic products.* Include dose or strength and number of times per day:

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Name: ______________________________ Today's Date: ____________

Please circle any symptoms you are having now or have had recently:

Constitutional:	Fever	Chills	Fatigue
Respiratory:	Shortness of breath	Wheezing	Cough
Gastrointestinal:	Heartburn	Diarrhea	Constipation
Musculoskeletal:	Muscle aches	Muscle tenderness	Muscle cramps
Dermatological:	Skin ulcers	Rash	
Neurological:	Dizziness	Headache	
Endocrinological:	Weight loss	Weight gain	
Hematological:	Bleeding	Easy bruising	
Psychiatric:	Anxiety	Depression	

Please list any other symptoms you are having now or have had recently:

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