Summit Cardiology Echocardiography Lab Patient Intake Form

Date: _____

Patient name: _____ DOB: _____ Height: _____ Weight:_____

Doctor ordering the study: _____

Primary care physician: _____

Reason for the study, if known: _____

Are you experiencing symptoms? (Check those that apply):

□ shortness of breath □ chest pain or pressure □ palpitations /heart pounding

□ dizziness/fainting □ other: _____

Have you had any of the following? (Check those that apply):

□ high blood pressure □ coronary artery disease □ a heart attack □ congestive heart failure

□ a stroke or "mini-stroke"

□ an infection of the heart valve /endocarditis □ rheumatic fever

□ congenital heart defect. Please specify, if known: _____

□ aortic aneurysm or enlarged aorta

□ atrial fibrillation □ other arrhythmia □ pacemaker □ AICD/cardiac defibrillator

□ a heart murmur □ mitral valve prolapse (MVP)

□ abnormal valve function. Check if known which valve: □aortic □mitral □tricuspid □pulmonic

Have you had previous heart surgery? (Check those that apply):

□ coronary bypass (CABG) □ valve surgery □ other_____

If you have had valve surgery, did you have a □ tissue valve □ mechanical (metal) valve

Which valve was repaired/replaced □aortic □mitral □tricuspid □pulmonic

What year was your surgery _____

Michaelene Deelstra, ARNP ● George Frank, MD, FACC ● Margaret Hall, MD ● Mary Hall, ARNP ● Julie Heyn, MD, FACC ● Chetan Pungoti, MD
Thomas Sawyer, MD ● David Warth, MD, FACC, FSCAI ● Gary Weeks, MD, FACC, FSCAI ● Daniel Wilkinson, Jr., MD, FACC ● Marko Yakovlevitch, MD, FACP, FACC
McMurray Medical Building ● 1536 N 115th St, Ste 200, Seattle, WA 98133 ● ph (206) 363-1004 ● fax (206) 363-3548 ● www.summitcardiology.com

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