SUMMIT CARDIOLOGY

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: _____

Referring Provider: _____ Today's Date: _____

Primary Care Provider(s): _____

Why are you here to see the cardiologist?

_____

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

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

Name: _____ Today's Date: _____

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 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: _____

_____

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 medications and reaction:

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:

Name: _____ Today's Date: _____

Please circle any symptoms that you have:

Constitutional:	Fatigue Fever Chills
	Unintentional weight loss Weight gain
Respiratory:	Wheezing Cough Asthma
Gastrointestinal:	Heartburn Indigestion Nausea Ulcers
	Diarrhea Constipation Black/tarry stool
Musculoskeletal:	Joint pains Muscle aches Muscle tenderness
Dermatological:	Skin ulcers Rash Itching
Neurological:	Temporary paralysis Permanent paralysis
	Weakness Stroke Numbness
Endocrinological:	Excessive thirst Excessive urination
Hemato/Onco-logical:	Bleeding Easy bruising Anemia Cancer
Psychiatric:	Anxiety Depression

Please list any other symptoms that you have:

_____

_____

_____

_____

_____

_____

_____

_____