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MEDICAL PRACTICE, PLLC
Cardiology

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Rebecca Boyea-Kertesz, P.A.C.
Kayc McHone, P.A.C.
Courtney Eggleston, P.A.C.

Pre-Examination Information

Patient Name _____ Date of Birth: _____ Date of Appointment: _____

Reason you are seeing a heart specialist: _____

Past Health History

Please list any recent hospitalizations or operations you have had:

Date	Type of illness or surgery	Name of Hospital	Location of Hospital

Check the box if you have now or have ever had any of the following conditions/illnesses:

☐ Cancer: Type _____

☐ Unexplained fevers	☐ Stroke	☐ Liver Disease	☐ Osteoporosis
☐ Prolonged fatigue	☐ Diabetes	☐ Arthritis	☐ Tuberculosis
☐ Abnormal chest x-ray	☐ Asthma	☐ Gout	☐ Chronic bronchitis
☐ Rheumatic fever	☐ Depression	☐ Kidney Stones	☐ Seizures or Epilepsy
☐ Kidney disease	☐ Chest pain	☐ Palpitations	☐ High blood pressure
☐ Stomach ulcers	☐ Pneumonia	☐ Heart Murmur	☐ Chronic lung disease
☐ Heart disease	☐ Heart attack	☐ Hepatitis	☐ Prostate disease
☐ Thyroid disease	☐Anxiety/Panic attacks		☐ Sleep Apnea

☐ Blood, albumin (protein) or sugar in urine

Please list present medications with dosages and how taken. Please bring all medications with you to your appointment.

Name of Medication	Dosage	How Taken

Do you use non-prescription medications, diet supplements, or Vitamins? If so, list below:

_____

_____

_____

Do you have allergies to any medications? If so, list below:

_____

_____

_____

Family Health History

	Age	Present Health, or if deceased, cause of death	Age of death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

Please place the appropriate letter in the space to indicate if blood relatives have and /or have had any of the following problems:

M-mother **F**-father **S**-sister **B**-brother **G**-grandparent **C**-children

____Heart disease	____Depression	____Crippling arthritis	____Lupus
____Suicide attempt	____Lung cancer	____Nervous breakdown	____Stroke
____High blood pressure	____Cervical cancer	____Glaucoma	____Gout
____High cholesterol	____Breast cancer	____Seizures/fits	____Epilepsy
____Thyroid problems	____Sudden death	____Uterine cancer	____Cancer
____Bleeding disorder	____Colon cancer	____Nervous disorder	____Diabetes
____Sickle cell disease	____Alcoholism	____Kidney disease	____Leukemia

Have you ever had any of the following? (if yes, write the place and year performed)

Cardiac stress test/echo _____
Cardiac catheterization _____
Echocardiogram _____

Occupation _____ **Employer** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Co-Inhabitant

Do you have: ☐ Health Care Proxy ☐ Living Will ☐ Do Not Resuscitate Order

Check areas below that relate to your current health status:

Review of systems	Yes	No	Comment/Explanation
General Health (Do you feel well?)	☐	☐	
Women: Post Menopausal Irregular bleeding Normal periods	☐	☐	
Heartburn, belching, nausea, bloated stomach, or difficulty swallowing? If yes, please explain.	☐	☐	
Loss of appetite? More than a 5 pound weight change in the last year?	☐	☐	
Abdominal pain, pressure, or discomfort?	☐	☐	
Change in bowel habits?	☐	☐	
Urinary problems (pain, burning or frequency)? Incontinence?	☐	☐	
Headaches, dizziness, loss of consciousness, or poor memory?	☐	☐	
Chest pain or shortness of breath, at rest or with exertion? Irregular or pounding heartbeat?	☐	☐	
Difficulty breathing, cough, or lung congestion?	☐	☐	
Changes in eye sight or eye pain?	☐	☐	
Loss of hearing? Ear or sinus pain? Ringing or buzzing in ears?	☐	☐	
Changes in self breast exam?	☐	☐	
Rash, skin discoloration or changes in birthmarks or moles?	☐	☐	
Bruising or bleeding?	☐	☐	
Bone or joint pain, muscle aches or loss of strength?	☐	☐	
Increased thirst, fatigue, loss of hair or dry skin?	☐	☐	
Swelling in neck, armpit, or groin?	☐	☐	
Depression or anxiety? Trouble sleeping?	☐	☐	
Allergies (food, drug or environmental)?	☐	☐	
Do you: Smoke? Drink alcohol? Drink caffeine? Use marijuana, cocaine, or other street drugs?	☐	☐	
Do you follow a special diet? Do you add salt at the table?	☐	☐	
Other:	☐	☐	

Signature of Patient _____ **Date** _____

Reviewed by _____ **Date** _____