INITIAL VISIT INTERVIEW

Please complete and bring to your appointment

Patient Name	Date of Appointment
Referring Physician	
Please briefly describe your symptoms	
What makes your symptoms worse?	

			Comments
Do your symptoms worsen with exercise?	Y	N	
Are you allergic to any medications?	Y	N	
Are you allergic to any other substances?	Y	N	

Medical history

Do you have any of the following conditions? Please check and comment if applicable.

	✓	When	Where	Outcome
Stroke or TIA				
Abnormal Heart Rhythm				
Sudden Death				
Diabetes				
Hypertension				
Congenital Heart Disease				
Coronary Artery Disease				
Thyroid Disease				
Valve Disease				
Heart Failure				
Myocardial Infarction				

Procedures

Please indicate if applicable

Procedure	✓	When	Where	Outcome
Non-Invasive Cardiac Testing				
• **Holter or Event Monitor**				
• **Stress Testing**				
• **Echocardiogram**				

Electrophysiology Study				
Catheter Ablation				
ICD or Pacemaker Implant				
Angioplasty				
Coronary Bypass Graft				
Valve Replacement				

Social history

Marital status: Single Married Divorced Separated Widowed

Number of Children, If any: _____

Do you smoke? No Yes

If yes, how long have you smoked? _____
If quit, when did you quit smoking? _____

Do you drink alcohol? No Yes
If yes, how much do you drink approximately? _____ drinks/week

Diet: _____Exercise Habits:_____

Family history

Family member	Age	Status
Father		**Alive** **Dead: Cause of death** _____
Mother		**Alive** **Dead: Cause of death** _____
Siblings		**Alive** **Dead: Cause of death** _____
		Alive **Dead: Cause of death** _____

Do any family members have any of the following conditions? Please check and comment if applicable.

	✓	Who	When	Outcome
Stroke or TIA				
Abnormal Heart Rhythm				
Sudden Death				
Diabetes				
Hypertension				

Congenital Heart Disease				
Coronary Artery Disease				
Thyroid Disease				
Valve Disease				
Heart Failure				
Myocardial Infarction				

Review of Systems

Please circle any of the following symptoms you have:

SYSTEM	SYMPTOMS		COMMENTS (including other)
General	Weight or Appetite	Fatigue Fever Chills or Night Sweats	
Skin	Rash Infection	Ulcer Mole	
HEENT	Headache Vision changes Hearing Problems	Difficult Swallowing Hoarseness	
Cardiovascular	Chest Pain Shortness of Breath	Edema	
Respiratory	Cough Difficulty in Breathing Blood with cough	Tuberculosis Pneumonia Wheezing	
Gastrointestinal	Constipation Diarrhea Jaundice Bloody Stool	Ulcers Heart Burn	
Breast	Lump or Mass	Bleeding	
Endocrine	Thyroid irregularities	Menopause	
Genitourinary	Painful discharge Painful urination	Blood in urine Increase or decrease in urination	
Hematology	Abnormal Bleeding Abnormal Bruising	Anemia Blood Transfusion	
Musculoskeletal	Joint Pain Muscle Weakness	Back Pain	