Port Charlotte CARDIOLOGY

PLEASE ANSWER ALL INFO BELOW DATE_____CHART #_____

Name:_____Age:_____DOB_____

Referred by:_____Primary Care Dr:_____

Pharmacy:_____ Lab Used:_____

Do you have, or have you ever had any of the following? Please check all the apply.

☐Weight Loss	☐ Lung disease	☐ Nausea	☐ Diabetes
☐Fever/chills	☐Asthma	☐Vomiting	☐Thyroid disease
☐Night sweats	☐Bronchitis	☐Diarrhea	☐arthritis
☐Prior heart attack	☐pneumonia	☐Blood in stool	☐Gout
☐Chest pain/Angina	☐Emphysema	☐ulcer	☐Muscle aches
☐Irregular heart beat	☐Shortness of breath	☐Hiatal hernia	☐Blood clots
☐Leg cramping	☐headaches	☐hepatitis	☐Anemia/ Bleeding
☐High Blood pressure	☐Seizures	☐Gallstones UTI	☐Cancer of _____
☐High Cholesterol	☐Dizziness	☐Urination @ night	☐Depression
☐Heart murmur	☐Fainting	☐Blood in urine	☐Anxiety
☐Rheumatic fever	☐Swelling / Edema		☐ Heart Failure

☐Pacemaker/ defib Type _____

Drug allergies (Please List)

*Are you allergic to IV dye, Iodine or shellfish? ☐Yes ☐NO

DATE SURGERY_____

Social History:

Occupation _____ ☐Retired

☐Married ☐Single ☐Divorced ☐Widowed

Family History	**Father**	**Mother**	**Siblings**
Age	_____	_____	_____
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐

Ever Used Tobacco ☐Yes ☐No

Packs Daily __ How Long ___ Quit _____

Coffee Daily ____ ☐Decaf ☐Regular

Alcohol Use ☐No ☐Yes How Often _____

Recreational Drugs ☐No ☐Yes Type _____

Exercise Routine ☐No ☐Yes How Often _____

Current Medications LIST ALL with DOSE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Comments to share with doctor