



**YOUR PERSONAL CARDIAC RISK FACTORS**

**Check all that apply to you**

- History of tobacco use
- Family history of heart disease (*immediate family, mother, father, brother, sister*)
- History of high cholesterol
- History of high blood pressure
- History of diabetes
- Prior history of heart disease
- History of obesity
- Sedentary/inactive lifestyle
- Age (*Male over age 45 – Female over age 55*)
- Menopausal female

**PAST MEDICAL HISTORY**

**Check all that apply to you**

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Previously healthy with no significant history</li> <li><input type="checkbox"/> Adrenal Insufficiency</li> <li><input type="checkbox"/> Amyloid</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Alzheimer’s Disease</li> <li>Arthritis: <input type="checkbox"/> Generalized           <ul style="list-style-type: none"> <li><input type="checkbox"/> Gouty</li> <li><input type="checkbox"/> Osteo</li> <li><input type="checkbox"/> Rheumatoid</li> </ul> </li> <li><input type="checkbox"/> Autoimmune Disorder</li> <li><input type="checkbox"/> Bicep Tear</li> <li><input type="checkbox"/> Bipolar Disease</li> <li><input type="checkbox"/> Birth Complications: Miscarriage, Still birth</li> <li><input type="checkbox"/> Blind</li> <li><input type="checkbox"/> BPH/Prostate Issues</li> <li><input type="checkbox"/> Barrett’s Esophagus</li> <li><input type="checkbox"/> Bell’s Palsy</li> <li><input type="checkbox"/> Bronchitis-Chronic</li> <li><input type="checkbox"/> Carpal tunnel</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Cellulitis</li> <li><input type="checkbox"/> Cirrhosis</li> <li><input type="checkbox"/> Colitis</li> <li><input type="checkbox"/> Crohn’s</li> <li><input type="checkbox"/> COPD/Emphysema</li> <li><input type="checkbox"/> CVA/Stroke/TIA</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Cancer, if yes, what kind: _____?</li> <li><input type="checkbox"/> Degenerative Joint Disease</li> <li><input type="checkbox"/> Dementia</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Diabetes: Type: <input type="checkbox"/> I <input type="checkbox"/> II</li> <li><input type="checkbox"/> Diabetic Neuropathy</li> <li><input type="checkbox"/> Diverticulitis</li> <li><input type="checkbox"/> DVT</li> <li><input type="checkbox"/> Endometriosis</li> <li><input type="checkbox"/> Erectile dysfunction</li> <li><input type="checkbox"/> Esophagitis</li> <li><input type="checkbox"/> Fibromyalgia</li> <li><input type="checkbox"/> Gastric Ulcer</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> GI Bleed</li> <li><input type="checkbox"/> Gallbladder Disease</li> <li><input type="checkbox"/> GERD</li> <li><input type="checkbox"/> Gout</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Hernia</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> Hodgkin’s Disease</li> <li><input type="checkbox"/> Hyperlipidemia (High Cholesterol)</li> <li><input type="checkbox"/> Hypertension</li> <li><input type="checkbox"/> Hyperthyroid</li> <li><input type="checkbox"/> Hypothyroid</li> <li><input type="checkbox"/> Irritable Bowel Syndrome</li> <li><input type="checkbox"/> Kidney Stone</li> <li><input type="checkbox"/> Leukemia</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Lupus</li> <li><input type="checkbox"/> Lymphoma</li> <li><input type="checkbox"/> Macular Degeneration</li> <li><input type="checkbox"/> Migraine Headaches</li> <li><input type="checkbox"/> Obesity</li> <li><input type="checkbox"/> Osteoporosis</li> <li><input type="checkbox"/> Pancreatitis</li> <li><input type="checkbox"/> Parkinson’s Disease</li> <li><input type="checkbox"/> Peripheral Neuropathy</li> <li><input type="checkbox"/> Polycystic Kidney Disease</li> <li><input type="checkbox"/> Pulmonary Embolus</li> <li><input type="checkbox"/> Pulmonary Fibrosis</li> <li><input type="checkbox"/> Preeclampsia</li> <li><input type="checkbox"/> Raynaud’s Phenomenon</li> <li><input type="checkbox"/> Renal Insufficiency</li> <li><input type="checkbox"/> Renal Failure</li> <li><input type="checkbox"/> Sarcoid</li> <li><input type="checkbox"/> Scoliosis</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Sleep Apnea</li> <li><input type="checkbox"/> Spinal Stenosis</li> <li><input type="checkbox"/> Syncope (Passing Out)/Near</li> <li><input type="checkbox"/> Trigeminal Neuralgia</li> <li><input type="checkbox"/> Ulcer Disease</li> <li><input type="checkbox"/> Varicose Veins</li> <li><input type="checkbox"/> Vertigo</li> <li><input type="checkbox"/> Other: _____</li> <li>_____</li> <li>_____</li> <li>_____</li> </ul> |
|---|---|--|

**PAST CARDIAC HISTORY**

**Check all that apply to you**

No previous history of cardiac disease

AAA

Aortic Aneurysm

Atrial Fibrillation (A-Fib)

CAD (Coronary Artery Disease)

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INFECTIOUS HISTORY**

**Check all that apply to you (Please provide month/year if available)**

No history of infectious diseases

Childhood illnesses of mumps, measles and chickenpox

COVID-19: \_\_\_\_\_

HIV: \_\_\_\_\_

Hepatitis: \_\_\_\_\_

A  B  C

Rheumatic Fever: \_\_\_\_\_

Pneumonia: \_\_\_\_\_

Cardiac Stent

Heart Attack

CHF (Congestive Heart Failure)

PVD (Peripheral Vascular Disease)

Syphilis: \_\_\_\_\_

Tuberculosis: \_\_\_\_\_

Sternal Wound: \_\_\_\_\_

Tick borne disease: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TRAUMA HISTORY**

**Check all that apply to you (Please provide year if available)**

No history of trauma

Burns (Major) : \_\_\_\_\_

Fracture: \_\_\_\_\_

Other: \_\_\_\_\_

Gunshot Wound: \_\_\_\_\_

Traumatic Amputation: \_\_\_\_\_

Traumatic Brain Injury: \_\_\_\_\_

**SURGICAL HISTORY**

**List all surgeries (Please provide year if available)**

\_\_\_\_\_

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## SOCIAL HISTORY & LIFESTYLE

### Alcohol use

Do you consume alcohol?  YES  NO

History of Alcohol Abuse

If Yes: How many drinks? \_\_\_\_\_

Daily

Weekly

Monthly

*1 Standard drink = 12oz beer, 5oz wine, 1.5oz (standard jigger) liquor*

### Smoking/Tobacco use

Do you currently smoke *cigarettes/smokeless cigarettes* or use *other tobacco* (Circle Type)?  YES  NO

Have you smoked in the past?  YES  NO How many years did you smoke \_\_\_\_\_ Packs per day? \_\_\_\_\_

When did you quit? \_\_\_\_\_

### Diet

Are you on any special diet (diabetic diet, etc.)?  YES  NO

If yes, what type? \_\_\_\_\_

Do you drink caffeinated beverages?  YES  NO If yes, how many per day? \_\_\_\_\_  
(Coffee, tea, soda, etc.)

### Exercise

No Regular Exercise

Some exercise

Exercises daily

Exercises on regular basis

*(30 minutes per day, at least 3 times per week)*

Type:

Aerobics

Running/Jogging

Walking

Weight Lifting

Other: \_\_\_\_\_

### Substance abuse

Do you have any history of drug use?  YES  NO

If yes, please specify \_\_\_\_\_

Any IV Drug use?  YES  NO

### Lifestyle

Single

Married

Widowed

Divorced

Separated

Partnered

### Occupation

Please list: \_\_\_\_\_

Retired

Unemployed

Student

### Residence

Lives alone

Lives with others'

Lives in a healthcare facility



**REVIEW OF SYMPTOMS (Please check if you are currently experiencing symptoms or indicate *No Symptoms*)**

**General**

- No Symptoms*
- Fatigue  Decreased exercise tolerance
- Unplanned recent weight  loss  gain  
How Much? \_\_\_\_\_ lbs.
- Recurrent chills and fever
- Other: \_\_\_\_\_

**Integumentary**

- No Symptoms*
- Rash  Itching  Skin Lesions
- Other: \_\_\_\_\_

**Eyes**

- No Symptoms*
- Decreased acuity  Blind
- Double vision (diplopia)  Changes in vision
- Other: \_\_\_\_\_

**Ears, Nose & Throat**

- No Symptoms*
- Hearing loss:  Partial  Complete
- Difficulty speaking  Nose bleeds
- Other: \_\_\_\_\_

**Respiratory**

- No Symptoms*
- Cough:  Dry  Productive
- Shortness of breath (Dyspnea):  
 At Rest  With Exertion
- Coughing up blood (Hemoptysis)
- Wheezing
- Other: \_\_\_\_\_

**Cardiovascular**

- No Symptoms*
- Chest pain  Palpitations
- Dizziness
- Swelling:  Ankles  Legs
- Short of breath:  At rest  With exertion
- Short of breath lying flat (orthopnea)
- Passing out (syncope)
- Leg fatigue/pain when walking
- Non-healing wounds
- Other: \_\_\_\_\_

**Gastrointestinal**

- No Symptoms*
- Nausea  Abdominal discomfort
- Blood in stool:  
 Bright  Dark/Tarry
- Diarrhea  Constipation
- Other: \_\_\_\_\_

**Musculoskeletal**

- No Symptoms*
- Chronic back pain  Joint pain
- Muscle weakness
- Other: \_\_\_\_\_

**Neurological**

- No Symptoms*
- Confusion  Headaches
- Vertigo
- Other: \_\_\_\_\_

**Psychiatric**

- No Symptoms*
- Feelings of anxiety or depression
- Change in:  
 Behavior  Mood  Personality
- Other: \_\_\_\_\_

**Endocrine**

- No Symptoms*
- Excessive thirst (polydipsia)
- Excessive urination (polyuria)
- Intolerance to cold
- Other: \_\_\_\_\_

**Hematological/Immunological**

- No Symptoms*
- Bleeding disorder
- Easy Bleeding  Easy Bruising
- Swollen Lymph Nodes
- Other: \_\_\_\_\_