

Pikes Peak Cardiology

Patient Medical History

NAME: _____ Date of Birth _____

What doctor sent you to us? _____ Why? _____

Do you have any history of heart disease? Y / N _____

Are you allergic to anything? Y N List: _____

Risk Factors

Smoking Y / N
High Blood Pressure Y / N
High Cholesterol Y / N
Diabetes Y / N
Overweight Y / N

Family History

Heart Disease Y / N
Stroke Y / N
Diabetes Y / N
High Blood Pressure Y / N
Please indicate family member:

Cardiac Symptoms

Shortness of Breath Y / N
Skipped Beats Y / N
Palpitations Y / N
Dizziness Y / N
Blackouts Y / N
Chest Pain Y / N

Please list any major surgeries:

- _____
- _____
- _____
- _____

Please list all Diagnostic Tests in the last 6 months: Locations/ Date

(ie: EKG, Blood Tests, Echocardiogram, Cardiac Catheterization, etc)

- _____
- _____
- _____
- _____

Medications and Supplements:

Please copy information off bottles if possible, bring with you, or attach a list.

| <u>Name</u> | <u>Dosage/Milligrams</u> | <u>Frequency Taken</u> |
|-------------|--------------------------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I attest that the above information is true and correct to the best of my belief.

Signature: _____ Date: _____