PATIENT INFORMATION

Date: _____

Name: _____

DOB:___/____/_____ Age:_____ Height: _____ Weight:_____ Sex: M / F

Use of tobacco: yes no # packs a day ____ for _____ yrs.

Use of alcohol: yes no Occasional or heavy

Does anyone in your family have a history of cardiovascular disease? Yes or no

List all medications you are currently taking and why:

_____ _____

_____ _____

_____ _____

Please circle all that apply current and/or history of:

Cardiovascular

Stroke
Asthma
Coronary Artery Disease
Emphysema (COPD)
High or low Blood Pressure
Poor Circulation
Heart or Valve Defects
Erectile Dysfunction
Ankle Swelling
Irregular Heart Rhythm
Irregular Pulse
Heart Attack
Peripheral Artery Disease
Pulmonary Artery Disease

General

Diabetes
Depression
Weight loss
Weight gain
Fatigue
Fibromyalgia
Edema
Loss of Sleep
High Cholesterol
Pace Maker
Vasculitis

Notes: