

Office Visit for

- Prevention
- Follow up visit
- Cardiac Specific Complaint

Chest pain

- occurrence: exercise stress cold after meal rest
- character: discomfort heaviness tightness choking burning
- location: retrosternal neck jaw shoulder epigastric
- associated: nausea sweating shortness of breath
- duration: <10 min 10 – 20 min 20 min
- frequency: once a month weekly daily relieved with rest
- pattern: worsening same better

Shortness of breath

- with: minimal exercise 1 flight of stairs 2 flights of stairs rest
- associated: chest pain palpitations lightheadedness
- pattern: worsening same better

Palpitations

- onset: sudden gradual
- occurrence: rest exercise coffee alcohol
- associated: chest tightness dyspnea lightheadedness
- termination: sudden gradual
- pattern: worsening same better

Lightheadedness/near syncope/syncope

- occurrence: sitting standing exercise
- after meals with urinating straining shaving
- onset: sudden no symptoms or
- with symptoms: nausea, warmth, blacking out
- associated: palpitations dyspnea chest pain
- duration: seconds minutes hours
- frequency: monthly weekly daily
- pattern: worsening same better

Cardio-Vascular History

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Coronary Artery disease | |
| <input type="checkbox"/> Valvular Disease/Heart Murmur | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Congenital Heart Disease | |
| <input type="checkbox"/> Acute Pericarditis | <input type="checkbox"/> Pericardial Effusion | <input type="checkbox"/> Constrictive Pericarditis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Atrial Flutter |
| <input type="checkbox"/> Supraventricular Tachycardia | <input type="checkbox"/> Ventricular Tachycardia | <input type="checkbox"/> Sinus node dysfunction |
| <input type="checkbox"/> Bradycardia | <input type="checkbox"/> Block | <input type="checkbox"/> Pacemaker-Defibrillator |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Defibrillator | |

- | | | | | |
|---|-------------------------------------|---|--|---|
| <input type="radio"/> Carotid disease | <input type="radio"/> Stroke | <input type="radio"/> TIA | <input checked="" type="checkbox"/> Diabetes | |
| <input type="radio"/> Peripheral Arterial Disease | <input type="radio"/> Renal Disease | <input type="radio"/> Venous Thrombosis | | |
| <input type="radio"/> Aneurysm | <input type="checkbox"/> abdominal | <input type="checkbox"/> thoracic | <input type="checkbox"/> other location | <input type="checkbox"/> family history of aneurysm |

Risk Factors, Cardio-Vascular

- Age** male > 45 years old female > 55 years old
- Family members with: Unexpected death, Heart attack, Cardiac death**
- father or male relative age < 55 years old
- mother or female relative age < 65 years old
- Smoking** yes no
- Hypertension** yes no
- HDL (high density lipoprotein)** <40 40 – 60 >60 mg/dL n/a

High Cholesterol high LDL normal LDL n/a

Framingham Risk Score < 10% 10-20% > 20% n/a

Body Mass Index [BMI] < 25 25 – 30 30-35 > 35 n/a

Risk Factors, Metabolic Syndrome

Waist male _____ female _____

Blood Pressure _____

Fasting Blood Sugar	<input type="checkbox"/> >100 mg/dl	<input type="checkbox"/> <100 mg/dl	<input type="checkbox"/> n/a
Triglycerides	<input type="checkbox"/> >150 mg/dl	<input type="checkbox"/> <150 mg/dl	<input type="checkbox"/> n/a
HDL male	<input type="checkbox"/> < 40 mg/dl	<input type="checkbox"/> >40 mg/dl	<input type="checkbox"/> n/a
female	<input type="checkbox"/> < 50 mg/dl	<input type="checkbox"/> >50 mg/dl	<input type="checkbox"/> n/a

Risk Factors, Chemotherapy related Cardiotoxicity

(to be completed by Oncology patients only)

prior Anthracycline dose _____ n/a
 prior Radiation Therapy site _____
 gender male female
 age > 50 y.o. <50 y.o.
 BMI >25 <25 n/a
 Hypertension yes no n/a
 Cardiac EF <55 % >55 % n/a

Medical History

<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD
<input type="checkbox"/> Pulmonary Hypertension	<input type="checkbox"/> GI bleeding	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Peptic Ulcer Disease	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Helicobacter Pylori
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hypert thyroidism	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Pheochromocytoma	<input type="checkbox"/> Parathyroidism
<input type="checkbox"/> Cushing's	<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Hyperaldosteronism
<input type="checkbox"/> RA <input type="checkbox"/> Lupus	<input type="checkbox"/> no	<input type="checkbox"/> Dermatomyositis
HIV <input type="checkbox"/> yes		<input type="checkbox"/> never tested

<input type="checkbox"/> Breast Ca	<input type="checkbox"/> Lung Ca	<input type="checkbox"/> Ovarian Ca	<input type="checkbox"/> Renal Ca
<input type="checkbox"/> Hodgkin Lymphoma		<input type="checkbox"/> Non-Hodgkin Lymphoma	

Seizures Parkinson Neurologic disorders _____
 Gynecological Disorders _____
 Gout Anemia Bleeding disorders _____



Allergies

None, Penicillin, Iodine, others: _____

Hospitalization or Surgery history

<u>Reason for hospitalization</u>	<u>Date</u>	<u>Reason for hospitalization</u>	<u>Date</u>
_____ / _____	_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____	_____ / _____

Have you had any of the following procedures?

	<u>Hospital</u>	<u>Location</u>	<u>Date</u>
Cardiac catheterization/Angiogram	_____ / _____	_____ / _____	_____ / _____
Angioplasty	_____ / _____	_____ / _____	_____ / _____
Echocardiogram	_____ / _____	_____ / _____	_____ / _____
Stress Test	_____ / _____	_____ / _____	_____ / _____
Holter or Event Monitor	_____ / _____	_____ / _____	_____ / _____

Family Medical History

Diabetes _____ Hypertension _____
 Stroke/TIA _____ Bleeding Disorder _____
 Cancer _____

Social History

Smoke: Packs per day _____ how long _____ when stopped _____

Exercise: Days per week _____ walk/jog _____ speed _____ how long _____

Coffee: cups per day _____ others _____

Alcohol: daily/weekend _____ amount per day _____

Sleep pattern _____ severe snoring _____ daytime sleepiness _____

Substance abuse: Drug type _____ how long _____

Diet: please describe a typical

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you have a weight scale in your home? yes no

How often do you check your weight? never weekly monthly other _____

Have you check our website www.HollywoodHeartCenter.com yes no