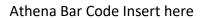


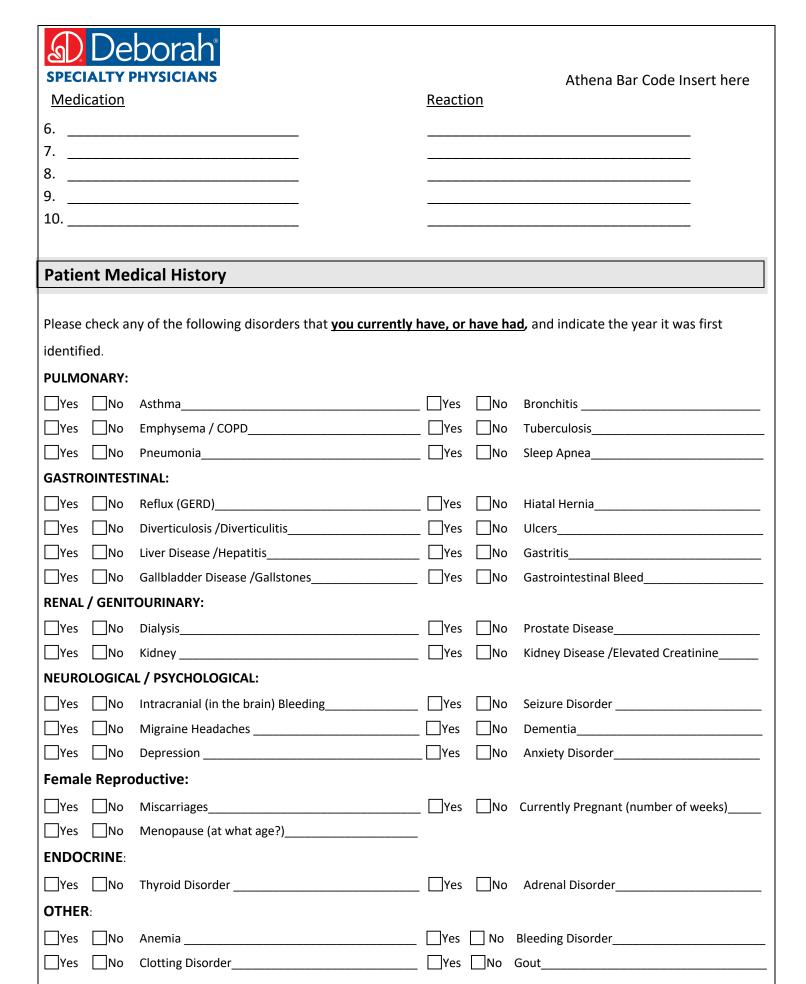


Date/		
Patient Name	Date of Birth	Social Security #
Address	Home Phone	Cell Phone
Emergency Contact	Phone Number	Relation
Primary Care Physician name		City / State:
Physician's Office phone #	Physician's C	Office FAX #
Preferred Lab name & address		
Preferred Radiology facility name & address		
Pharmacy Name & FAX #		
CHIEF COMPLAINT		
What concerns are you here for today?		
PROBLEM LIST		
Yes No Rheumatic Fever Yes No Murmur Yes No Abnormal Heart Valve Yes No Endocarditis (infected heart lining/valve Yes No Abnormal ECG Yes No Angina (heart pain) Yes No Heart Attack Yes No Heart Disease (born with/congenital) VASCULAR: Yes No Carotid Artery Disease Yes No Renal (Kidney) Artery Disease Yes No Peripheral (leg or arm) Artery Disease	Yes No Coro Yes No Arrh Yes No Prev Yes No Defile Yes No Mar Yes No Mar Yes No Hosp Yes No Othe Yes No Hear Yes No Any Yes No Any Yes No Oth	pad, and the year it was first identified. party Artery Disease ythmia / Abnormal Rhythm prious Cardiac Arrest prillated /"Shocked" partial Disease (sac surrounding heart) fan syndrome pitalized for cardiac reasons per type of heart disease pri Failure / Cardiomyopathy pake or TIA (mini-stroke) history of aneurysm f (clots in leg) per type of Vascular Disease





COR	ONARY	RISK FACTORS					
Yes							
Yes	Шио	Abnormal Cholesterol / 1	rigiycerides		∐ио	Currently Smoking?	_
Please	list all m	nedications, non-prescript	ions, vitamins and suppl	ements, attac	hing ad	ditional pages if necessary.	
<u>Na</u>	me of M	ledication/Supplement	Dose/Strength		How ma	any/How often/When	
1.							
2.							
3.							
4.							
5.							
6.							
7.							
							
							
							
							
19.							
20.							
ALLE	RGIES	/ INTOLERANCES TO	MEDICATIONS				
N.A.	a di cati a	n	D	opetion			
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SPECIALTY PHYSICIANS	Athena Bar Code Insert here
Yes No Arthritis	Yes No Ambulate with assistance
Yes No HIV	Yes No Reaction to iodine contrast
Yes No Previous exposure to iodine contrast	Yes No Vertigo
Yes No Cancer (type)	_
Yes No Autoimmune Disorders (i.e., Lupus, Hashimo	otos)
Yes No Previous Weight Loss Meds (i.e., Fen Phen)	
Please list any other health problems that are not on the list	··
SURGICAL HISTORY / OPERATIONS	
Please list any surgeries you have had:	
Surgery Date	Surgeon Location
·	
SOCIAL HISTORY	
Marital Status Single Married Divorced	Separated Widowed Domestic Partner
Number of children With whom do you liv	e?
Do you have a Medical Power of Attorney? Yes No	Who? Relationship:
Advanced Directive Yes No Do Not Res	suscitate
Healthcare Proxy Yes No Who?	Relationship:
Living Will Yes No Date:	
Currently Employed or Retired? If emplo	oyed, your current occupation
Your past occupation(s)	
	Secondary language
Leisure activities (include any hobbies)	
	types:
	age Readings:
, , , , , , , , , , , , , , , , , , , ,	· · · · · · · · · · · · · · · · · · ·
	4



Athena Bar Code Insert here

Do you use tobacco? Y	es Formerly	Never	
Cigarettes	per day # of \	ears Smoked	Quit Date
Cigars	per day # of `	rears Smoked	Quit Date
Pipes	per day # of `	Years Smoked	Quit Date
Chewing tobacco	per day # of `	Years Smoked	Quit Date
Do you use alcohol? Yo	es Formerly	Never	
Describe your use:			
Rarely Social	Daily F	requently O	ccasional Quit Date
Type:	How much?		
Beer	cans per day	/ / per week	z / per month
Wine	glasses per d	ay / per weel	c/ per month
Spirits	glasses per	day / per weel	c/per month
Do you use caffeine? Y Type: Caffeinated Coffee? Caffeinated Tea? Caffeinated Soda?	cups per day /	per week per week	
Do you use recreational drug	s? <u>Yes</u>	Formerly	Never
Type: Amo	unt:	Start / Quit Dates:	
Marijuana	per day	Years Smoked	Quit Date
Cocaine	per day	Years Smoked	Quit Date
Methamphetamine	per day	Years Used	Quit Date
Other	per day	Years Used	Quit Date



Athena Bar Code Insert here

Exercise?	
☐ No/Sedentary ☐ Occasional ☐ Regular ☐ Active Lifestyle ☐ Physically unable to €	exercise
Type: How much:	
Aerobics How long? (Mins.) How often per week?	
Cycling How long? (Mins.) How often per week?	
Dancing How long? (Mins.) How often per week?	
Jogging How long? (Mins.) How often per week?	
Running How long? (Mins.) How often per week?	
Swimming How long? (Mins.) How often per week?	
Team sport How long? (Mins.) How often per week?	
Walking How long? (Mins.) How often per week?	
Weights How long? (Mins.) How often per week?	
Please choose the type of diet you are currently on:	
Type: How well do you follow it?	
Regular	
Low fat/Chol Strictly Usually Occasionally Non-compliant with die	et
Low salt Usually Occasionally Non-compliant with die	et
☐ Diabetic ☐ Strictly ☐ Usually ☐ Occasionally ☐ Non-compliant with die	et
Renal Strictly Usually Occasionally Non-compliant with die	et .
☐ No Added Salt ☐ Strictly ☐ Usually ☐ Occasionally ☐ Non-compliant with die	et .
Weight Loss Strictly Usually Occasionally Non-compliant with die	et .
Low Carb Strictly Usually Occasionally Non-compliant with die	et .
Vegetarian ☐ Strictly ☐ Usually ☐ Occasionally ☐ Non-compliant with die	et .



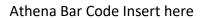
FAMILY HISTORY

Please indicate below if your FATHER, MOTHER, SIBLING(S), or CHILDREN have ever been diagnosed with any of the following conditions, by writing the age (not a check mark) at which the condition first occurred in the appropriate box.

Note: If there is no history of these conditions or if they are unknown, then check the None or Unknown box in the appropriate column.

Condition	Father	Mother	Sister(s)	Brother(s)	Children
Angina					
Heart Attack					
Angioplasty					
Heart Surgery					
Abnormal Heart Rhythm					
Sudden/Unexpected Death					
Stroke/TIA (mini-stroke)					
Blood Clots					
Heart Failure/Cardiomyopathy					
Aneurysm					
None of the above					
Unknown					
Current age					
Deceased age					

Other family members (aunts, uncles, cousins, grandparents) with heart problems:				





Patient Name			Date of Birth		
Please check the "Yes" or "No" bo symptoms in the last three month		if you a	re experiencing or have experienced any of the f	ollowing	g signs or
REVIEW OF SYSTEMS					
CONSTITUTIONAL: Significant weight loss Significant weight gain	Yes	No	CARDIAC: Chest Pains Chest Pressure	Yes	No
ENMT: Excessive Snoring	Yes	No	Shortness of breath Difficulty breathing while lying flat Awakening with breathing difficulty	Yes	No
RESPIRATORY Coughing up blood	Yes	No	Swelling in feet/ankles	Yes	No
GASTROINTESTINAL: Blood in stool (black stool)	YES	No	Palpitations	Yes	No
GENITOURINARY : Blood in urine	Yes	No	Nearly passing out spells Passing out spells	Yes	No
VASCULAR: Calf pain with walking	Yes	No	Any other reason why you need to see a card	iologist	<u>?</u>
MUSCULOSKELETAL: Muscle pain at rest	Yes	No			- - -
NEUROLOGICAL: Dizziness	Yes	No			- - -
PSYCHIATRIC: Excessive stress	Yes	No			
ENDOCRINE: Feel cooler	Yes	No			
HEMATOLOGICAL: Unusual bleeding	Yes	No			
Thank you for taking the time t	o complete	this qu	estionnaire!		
Patient Signature					
Date:			Reviewed By:		

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