LOURDES CARDIOLOGY NEW PATIENT FORM

Welcome to our practice! Our Doctors and staff are here to serve you and look forward to a productive and healthy relationship. Please take some time to answer the questionnaire below to make your appointment more efficient and improve your overall experience.

Demographics:

Name:_____ D.O.B._____

History of Present Illness:

Do you have any of the following ***symptoms***?

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Passing Out
- ☐ Leg Pain
- ☐ Leg Swelling
- ☐ Palpitations
- ☐ Lightheadedness/dizziness
- ☐ Black or Bloody Stools
- ☐ Abdominal Pain
- ☐ Weight Gain/loss

Past Medical History:

Have you ever had any of the following ***cardiovascular conditions***?

- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Arrhythmia (irregular heart beat)
- ☐ Syncope (loss of consciousness)
- ☐ Aneurysm (abdominal or thoracic)
- ☐ Peripheral Arterial Disease/PAD
- ☐ Stroke or Mini Stroke
- ☐ Atrial Fibrillation/Flutter
- ☐ Varicose Vein
- ☐ DVT (deep vein thrombosis)
- ☐ Pulmonary Embolism
- ☐ Coronary Artery Disease/Stents
- ☐ Aortic Stenosis
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Cardiac Arrest
- ☐ Congestive Heart Failure
- ☐ Carotid Artery Disease

Other Cardiac Conditions (please list):

_____ _____

_____ _____

_____ _____

Have you ever had any of the following *cardiac procedures/surgeries*?

- ☐ Coronary Artery Stent/Angioplasty Year_____
- ☐ Coronary Artery Bypass Surgery/CABG Year_____
- ☐ Heart Valve Replacement/Repair/TAVR Year_____
- ☐ Pacemaker or Defibrillator Implant/ICD Year_____
- ☐ Ablation (For Atrial Fib/flutter/SVT/WPW) Year_____
- ☐ Carotid Endarterectomy/Stent Year_____
- ☐ Abdominal Aortic Aneurysm Repair Year_____
- ☐ Lower Extremity Artery Bypass/Stents Year_____

Have you ever had any other surgeries?

- ☐ Cholecystectomy (Gallbladder) Year_____
- ☐ Colon Resection Year_____
- ☐ Prostate Year_____
- ☐ Cataract Year_____
- ☐ Mastectomy/Breast Lumpectomy Year_____
- ☐ Hip or Knee Year_____
- ☐ Thyroid Year_____
- ☐ Back Year_____

☐ Bladder Year_____ ☐ Hernia Year_____

Other Surgeries and year performed:

_____ _____

_____ _____

Allergies:

☐ Iodine/IV Dye ☐ ACE Inhibitors ☐ Aspirin/NSAIDS ☐ Penicillin
☐ Sulfa/Bactrim ☐ Erythromycin ☐ Latex

Please list other medications to which you are allergic:

_____ _____

_____ _____

Have you ever been diagnosed with any of the following *medical conditions*?

Gastrointestinal Disease
- ☐ Hiatal Hernia
- ☐ GI Bleed
- ☐ GERD/Reflux
- ☐ Peptic Ulcer Disease
- ☐ Barrett's Esophagitis
- ☐ Fatty Liver
- ☐ Gallstones
- ☐ Hepatitis
- ☐ Pancreatitis
- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

Blood Disease
- ☐ Anemia
- ☐ Low Platelets
- ☐ Blood Clots
- ☐ Nose Bleeds
- ☐ Blood Transfusion
- ☐ Leukemia
- ☐ Lymphoma
- ☐ HIV

Endocrine Disease
- ☐ Hypothyroidism
- ☐ Thyroid Nodule
- ☐ Hyperthyroidism/Graves
- ☐ Diabetes

Lung Disease
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Asthma
- ☐ Pneumonia
- ☐ Lung Nodules
- ☐ Pulmonary Embolism

Kidney Disease
- ☐ Chronic Renal Failure
- ☐ Hemodialysis
- ☐ Blood in Urine
- ☐ Kidney Stones

Orthopedic Disease
- ☐ Chronic Back Pain
- ☐ Degenerative Arthritis
- ☐ Gait Imbalance
- ☐ Scoliosis
- ☐ Osteoporosis

Rheumatologic Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus

Psychiatric Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Dementia

Neurological Disease
- ☐ Stroke
- ☐ TIA
- ☐ Seizure
- ☐ Spinal Stenosis
- ☐ Herniated Disc
- ☐ Neuropathy
- ☐ Sciatica
- ☐ Parkinson's

Cancer
- ☐ Breast
- ☐ Lung
- ☐ Prostate
- ☐ Colon
- ☐ Skin
- ☐ Bladder
- ☐ Kidney
- ☐ Liver

Eye Disease
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration

Skin Disease
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Basal Cell Cancer

Other Conditions:

Medications: Please list name of medication, dosage, and place an "x" under frequency:

Name of Medication	Dose (MG)	Once Daily (QD)	Twice Daily (BID)	Three Times Daily (TID)	Other

Family History: Place an "X" next to condition where applicable:

Relative	Alive (Age)	Deceased (Age)	High Blood Pressure	High Cholesterol	Heart Stents or Bypass	Heart Attack	Stroke	Diabetes	Aneurysm	Sudden Death	Blood Clots
Mother											
Father											
Sibling											
Sibling											
Sibling											

Social History:

Are you a current smoker? ☐ Yes ☐ No If so, how many packs per day? _____

Have you smoked in the past but quit? ☐ Yes ☐ No What year did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If so, how often do you drink? _____

Have you ever abused any illicit drugs? ☐ Yes ☐ No

If so, please list: _____

In order to help you get the most out of your experience today please note something you would like to speak to your Cardiologist about:_____

_____

_____