Drs. Bartlett & Esnard, PC at

HEART OF GEORGIA CARDIOLOGY

Cardiovascular Disease and Invasive Cardiology

Patient History

Date_____

Name_____Date of Birth_____ Age_____ Referring physician_____

Reason for referral_____

Have you been seen by a Cardiologist before Y/N If yes, please list name/date_____

Marital Status: M___D____S____W___#yrs___ Work___Retired___ Occupation_____

Smoke: No____ Yes____ #packs per day___ #yrs____ If former smoker, year stopped _____

Alcohol: No____ Yes____ Frequency/Amount _____

Caffeine (#cups per day): Coffee____ Tea____ Soft drinks___ Diet/Appetite_____

Height_____ Weight_____ Recent loss/gain_____ Exercise: No_____ Yes_____ Frequency_____

Allergies (include reaction)_____

_____

Family History	Living or cause of death/age of death	Heart Disease?	Diabetes?	Cancer(which type?)
Mother AGE:				
Father AGE:				
Child (M or F) AGE:				
Child (M or F) AGE:				
Child (M or F) AGE:				
Brother AGE:				
Brother AGE:				
Brother AGE:				
Sister AGE:				
Sister AGE:				
Sister AGE:				

Drs. Bartlett & Esnard, PC at

HEART OF GEORGIA
CARDIOLOGY

Cardiovascular Disease and Invasive Cardiology

Patient History Date_____

Drs. Bartlett & Esnard, PC at

HEART OF GEORGIA
CARDIOLOGY

Cardiovascular Disease and Invasive Cardiology

Patient History Date_____

If needed, use this space to list any additional relevant additional family history:

_____

_____

_____

_____

List any surgeries or hospitalizations you have had, please include dates.

_____

_____

_____

_____

_____

System Review: Please circle all that apply to you.

Neurological: Dizziness, Headaches, Loss of sensation, other-describe_____

Eyes/Ears: Glasses or Contacts, Glaucoma, Hearing loss, other-describe_____

GI: Indigestion, GERD, Heatal hernia, Diarrhea, Constipation, other-describe_____

Endocrine: Diabetes, hypo or hyperthyroidism, other-describe_____

Muscloskeletal: Arthritis, Joint pain, Muscle pain or weakness, other-describe_____

Respiratory: Asthma, COPD, Shortness of breath, other-describe_____

Cardiovascular: High blood pressure, heart disease, irregular or rapid heartbeat, Pacemaker, AICD, heart failure,

Leg cramps while walking, other-describe_____

Please indicate which of these procedures you have had, <u>including date</u> and <u>location</u>:

EKG_____**Echocardiogram**_____

Holter or Event Monitor_____**Heart Catheterization**_____

Angioplasty or stent(s)_____**Heart Surgery**_____

Lab Work: _____

Drs. Bartlett & Esnard, PC at

HEART OF GEORGIA
CARDIOLOGY

Cardiovascular Disease and Invasive Cardiology

Patient History Date_____

List all medications including over the counter medications and dietary supplements:

NAME OF MEDICATION	DOSE/MG	HOW OFTEN TAKEN

Drs. Bartlett & Esnard, PC at

HEART OF GEORGIA
CARDIOLOGY

Cardiovascular Disease and Invasive Cardiology

Patient History

Date_____

Circle YES or NO to the following:

Do you have a living will or advance directive? YES or NO

Have you ever had a blood transfusion? YES or NO if yes, when? _____

Do you have a family history of heart disease? YES or NO if yes, who? _____

Do you have any religious beliefs? YES or NO if yes, what belief? _____

Have you traveled outside the United States within the last year? YES or NO if yes, where? _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE: _____

Signature_____

Date_____