

REGIONAL CARDIOLOGY ASSOCIATES, P.L.C.

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HEALTH ASSESSMENT

Name	Date		
Referring MD	Age	Ht	Wt
Current Problem (Reason for seeing Cardiologist)			

Social History	Past Medical History
Occupation	Surgeries
Retired	
Marital Status M S D W	
Alcohol Use Daily? Amt	Have you had a heart cath? Year
Smoker? Amount Years	Have you had a stress test? Year
Quit? When	

Current Medications	Cardiac Risk Factors
	Are you currently being treated for?
	High Blood Pressure Yes No
	Diabetes Yes No
	High Cholesterol Yes No
	Has anyone in your immediate family had:
	Heart attack? Who? Age?
List all allergies:	Stroke? Who? Age

Medical Conditions

Please indicate any of the following problems you have experienced:

- | | | |
|---|---|---|
| 1. <input type="checkbox"/> Previous heart attack | 12. <input type="checkbox"/> Stomach ulcers, hiatal hernia | 22. <input type="checkbox"/> Constant leg pain |
| 2. <input type="checkbox"/> Chest pain or angina | 13. <input type="checkbox"/> Liver cirrhosis, hepatitis | 23. <input type="checkbox"/> Burning in leg(s) |
| 3. <input type="checkbox"/> Shortness of breath | 14. <input type="checkbox"/> Arthritis, bursitis | 24. <input type="checkbox"/> Tingling in leg(s) |
| 4. <input type="checkbox"/> Irregular heart beat | 15. <input type="checkbox"/> Stroke, blood clots | 25. <input type="checkbox"/> Numbness or loss of sensation |
| 5. <input type="checkbox"/> Fast heartbeat | 16. <input type="checkbox"/> Heart valve problems | 26. <input type="checkbox"/> Glaucoma |
| 6. <input type="checkbox"/> Dizziness | 17. <input type="checkbox"/> Cold legs | 27. <input type="checkbox"/> Kidney/urinary system (prostate, bladder or kidney problems) |
| 7. <input type="checkbox"/> Passing out | 18. <input type="checkbox"/> Poor wound healing | 28. <input type="checkbox"/> Skeletal/muscular (arthritis, bursitis, etc.) |
| 8. <input type="checkbox"/> Swelling of feet, ankles or hands | 19. <input type="checkbox"/> Hair loss from toes and feet | 29. <input type="checkbox"/> Neurologic (paralysis, stroke, seizures, etc.) |
| 9. <input type="checkbox"/> Thyroid problems | 20. <input type="checkbox"/> Shiny skin | 30. <input type="checkbox"/> Cancer |
| 10. <input type="checkbox"/> Lungs (asthma, TB, pneumonia) | 21. <input type="checkbox"/> Pain during exercise, relieved by rest | |
| 11. <input type="checkbox"/> Rheumatic Fever | | |