DuPage Medical Group
CARDIOLOGY

STRONG HEART SMART HEART

Nuclear Cardiology Accredited Nuclear Cardiology Laboratory

ICAEL Accredited Echocardiography Laboratory

Clinical Assessment

Home Phone Number (_____) _____

Work Phone Number (_____) _____

Primary Physician: _____

Referring Cardiologist: _____

Place Identification Label Here

History Obtained from: ☐ Patient ☐ Family ☐ Hospital Records ☐ Transfer Records
☐ Other _____

Major (Chief) Complaint: _____

Past Medical History:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Cardiovascular History	Associated Signs/Symptoms	Risk Factors
☐ Heart Murmur	☐ Dizziness on standing	☐ High Blood Pressure
☐ Stroke/TIA	☐ Shortness of breath with activity	☐ Diabetes
When? _____	☐ Awakening from sleep with	☐ High Cholesterol
☐ Rheumatic Fever	shortness of breath	☐ Minimal Exercise
☐ Peripheral Vascular Disease	☐ Swelling of the ankles	☐ Family history of heart disease
☐ Pulmonary Embolus/Blood Clots	☐ Sleeps with greater than 2 pillows	☐ Post-menopausal/not on estrogen
When? _____	☐ Palpitations	(Natural/Surgical)
☐ Bypass Surgery	☐ Passing out spells	☐ Smoking _____Packs/Day
When? _____	☐ Pain in legs when walking	Years _____
☐ Angioplasty	☐ Chest pain	Quit _____
When? _____		☐ Overweight
☐ Congestive Heart Failure		
☐ Pacemaker/Defibrillator		
When? _____		
☐ Heart Attack		
When? _____		
☐ NONE OF THE ABOVE	☐ NONE OF THE ABOVE	☐ NONE OF THE ABOVE

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Social History: ☐ Married ☐ Single ☐ Significant Other ☐ Divorced

Health Status of significant other: _____

Children: _____

Health Status of Children: _____

Occupation: _____

Consume Alcohol	Drug Use	Tobacco Use	Caffeine Use
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How Often? _____	How Often? _____	How Often? _____	How Often? _____
_____	_____	_____	_____

REVIEW OF SYSTEMS

In General:
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Cancer
- ☐ Anesthetic reaction
- ☐ Night Sweats
- ☐ None

Eyes:
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other_____
- ☐ None

Ears, Nose, Throat:
- ☐ Deafness
- ☐ Vertigo/Dizziness
- ☐ Ringing on ears
- ☐ Other_____
- ☐ None

Skin:
- ☐ Skin rash
- ☐ Other_____
- ☐ None

Musculoskeletal:
- ☐ Arthritis
- ☐ Amputation
- ☐ Gout
- ☐ Back pain
- ☐ Other_____
- ☐ None

Psychiatric:
- ☐ Depression
- ☐ Other_____
- ☐ None

GI:
- ☐ Hiatal hernia
- ☐ Ulcers/bleeding from gastrointestinal tract
- ☐ Hepatitis
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Acid reflux
- ☐ Other_____
- ☐ None

Hematology:
- ☐ Easy bleeding
- ☐ Blood transfusions
- ☐ None

Renal:
- ☐ Prostate
- ☐ Kidney dysfunction
- ☐ Incontinence/loss of urine
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Other_____
- ☐ None

Allergies & Immunology:
- ☐ Immune disorder
- ☐ Other_____
- ☐ None

Respiratory:
- ☐ Sleep apnea/breathing stops while sleeping
- ☐ Snoring
- ☐ Emphysema
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ None

Glandular/Endocrine:
- ☐ Thyroid
- ☐ Uric acid
- ☐ Other_____
- ☐ None

Neurological:
- ☐ Tremors
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ None

☐ ALL OTHER SYSTEMS NEGATIVE

Comments on all check items:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Past Surgeries/Significant Illnesses: | Date: | MD/Hospital:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication (please include over the counter and vitamins) | Dosage per day

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies/Intolerances _____

_____

_____

Allergic to X-Ray dye ☐ Yes ☐ No ☐ Unknown

Family History	Illnesses	Deceased	Living
Mother:			
Father:			
Brother:			
Brother:			
Sister:			
Sister:			

Signature _____