HEART.SMART
Living to the best of your health.

Your Appointment is Scheduled for:

DAY	TIME

CANCELLATION POLICY

Please inform us at least 72 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients. Please note that we reserve two hours of time with our staff for your appointment, so late cancellations significantly affect us.

Patients who cancel or reschedule less than 72 hours prior to their appointment will be charged a $200 cancellation fee.

Please contact our office if you have any questions.

APPOINTMENT PREPARATION INSTRUCTIONS

1) Fasting

- Please refrain from eating for eight (8) hours prior to your visit
- Please DO drink water, but avoid all other beverages
- You may take medications with water
- Please refrain from consuming alcohol for 24 hours prior to your visit
- You are welcome to bring a snack to eat after the fasting portions of your tests have been completed. We will have healthy snacks and drinks on hand for you.

2) Clothing

Because your visit includes an EKG, you should wear appropriate clothing..

3) Eye Preparation

Your appointment will include photos of the back of your eye(s). Although we will not dilate your eyes, if you are wearing contact lenses, these will need to be removed for this test. In preparation for this, please bring any supplies you may need to remove your contacts, or wear glasses.

4) Medical History

Please fill out as much of the Patient Medical History Form as possible prior to your appointment. Some of the questions regarding family history are critical for formulating an accurate “risk score” and providing a comprehensive medical evaluation, and may require inquiry or research. Our staff will assist you in filling out information you have questions about.

PATIENT MEDICAL HISTORY

Please complete this form and bring it with you to your appointment. If you have questions or need assistance, we will review this form with you during your visit.

A detailed family medical history will help our medical providers interpret the history of disease in your family and identify patterns that may be relevant to your own health. This form is needed to assess your risk of certain diseases, determine which diagnostic tests to order as well as type and frequency of screening tests, identify a condition that might not otherwise be considered, and assess your risk of passing a condition on to your children.

1) Demographics

Name _____ Date of Birth ___/___/___

Address _____ Gender _____

City _____ State _____ Zip _____ Email address (kept confidential) _____

Phone #1 (___) _____

Phone #2 (___) _____

☐Check here if you do NOT want email communication

2) Social History

Marital Status ☐Single ☐Divorced ☐Married ☐Widowed ☐Other:

Living ☐Alone ☐Spouse/Partner ☐Relative ☐Children ☐Other:

Heritage ☐Asian ☐African American ☐White/Caucasian ☐Hispanic ☐Other:

Occupation: _____ Job Title/Description: _____

Exercise: Do you get 30 min. of steady physical exertion/exercise 3-4 times per week? ☐Y ☐N

☐Walking ☐Running ☐Jogging ☐Swimming

☐Biking ☐Household Chores ☐Yard Work ☐Other _____

Do you have physical conditions that limit your ability to exercise? ☐Y ☐N Specify: _____

Tobacco Use: ☐Never Used Tobacco ☐Cigarettes # Per Day _____ # Of Years _____

☐Ex-Tobacco User ☐Cigars # Per Day _____ # Of Years _____

☐Currently Use ☐Pipe # Per Day _____ # Of Years _____

Alcohol Use: ☐Y ☐N If yes, indicate on average how much and check day, week or month

_____Beers per: ☐Day ☐Week ☐Month

_____Glasses of wine per: ☐Day ☐Week ☐Month

_____Mixed drinks per: ☐Day ☐Week ☐Month

Family History: Has any blood relative of yours had a heart attack or stroke before the age of 60? ☐Y ☐N

Personal History: Have you ever had a heart attack, stroke, stent, cath lab procedure involving your heart? ☐Y ☐N

Name: _____ DOB: _____ Date: _____

3) Personal History - 1

Check any of the conditions that you currently have or have had in the past

Please explain if the answer is yes

Cardiovascular

High blood pressure	☐Y ☐N
High cholesterol	☐Y ☐N
Diabetes	☐Y ☐N
Heart failure	☐Y ☐N
Heart murmur	☐Y ☐N
Chest pain or Angina	☐Y ☐N
Heart skips a beat	☐Y ☐N
Heart beats too fast	☐Y ☐N
Passing out spells	☐Y ☐N
Rheumatic fever	☐Y ☐N
Feet, ankle or leg swelling	☐Y ☐N
Short of breath at rest	☐Y ☐N
Short of breath with exercise	☐Y ☐N
Short of breath lying down	☐Y ☐N
Problems sleeping	☐Y ☐N
Sexual dysfunction	☐Y ☐N
Frequent urination	☐Y ☐N
Abdominal pain	☐Y ☐N

Genitourinary

Burning or painful urination	☐Y ☐N
Blood in urine	☐Y ☐N
Bladder infections	☐Y ☐N
Incontinence, dribbling	☐Y ☐N
Kidney stones	☐Y ☐N
Irregular menses (female only)	☐Y ☐N

Ears, Nose, Mouth

Loss of smell	☐Y ☐N
Nose bleeds	☐Y ☐N
Sinus problems	☐Y ☐N
Runny nose	☐Y ☐N
Postnasal drip	☐Y ☐N
Earache or drainage	☐Y ☐N
Hearing loss	☐Y ☐N
Ringing in ears	☐Y ☐N
Sores in mouth	☐Y ☐N

Endocrine

Night sweats	☐Y ☐N
Excessive thirst	☐Y ☐N

Gastrointestinal

Rectal bleeding	☐Y ☐N
Blood in stool	☐Y ☐N
Loss of appetite	☐Y ☐N
Heartburn or indegestion	☐Y ☐N
Black or tarry stools	☐Y ☐N
Frequent diarrhea	☐Y ☐N
Difficulty Swallowing	☐Y ☐N
Nausea or vomiting	☐Y ☐N
Vomiting of blood	☐Y ☐N
Chronic constipation	☐Y ☐N
Stomach ulcer	☐Y ☐N

Name:_____ DOB:_____ Date:_____

3) Personal History - 2

Check any of the conditions that you currently have or have had in the past

Please explain if the answer is yes

Head and neck

Swelling in neck	☐Y ☐N
Prolonged hoarseness	☐Y ☐N
Frequent sore throat	☐Y ☐N
Pain or stiffness in neck	☐Y ☐N

Eyes

Glasses or contacts	☐Y ☐N
Double, failing vision	☐Y ☐N
Dry eyes	☐Y ☐N
Pain or light sensitivity	☐Y ☐N

Musculoskeletal

Swollen or red joints	☐Y ☐N
Poor leg circulation	☐Y ☐N
Arm or leg weakness	☐Y ☐N
Leg cramps	☐Y ☐N
Difficulty in walking	☐Y ☐N
Arthritis	☐Y ☐N
Inflammatory Disease (psoriasis)	☐Y ☐N

Neurologic

Light headed or dizziness	☐Y ☐N
Speech distrubances	☐Y ☐N
Convulsions or seizures	☐Y ☐N
Numbness or tingling	☐Y ☐N
Frequent headaches	☐Y ☐N
Memory loss	☐Y ☐N
Paralysis or weakness	☐Y ☐N

Skin

Rash, dryness, itching	☐Y ☐N
Change in nails or skin color	☐Y ☐N
Bleeding, bruising tendencies	☐Y ☐N

Lungs

Cough with sputum or blood	☐Y ☐N
Wheezing	☐Y ☐N
Asthma	☐Y ☐N

Psychiatric

Depression	☐Y ☐N
Anxiety	☐Y ☐N
Nervous breakdown	☐Y ☐N
Alcohol problems	☐Y ☐N
Physical, verbal, sexual abuse	☐Y ☐N

Misc.

Fever or chills	☐Y ☐N
Recent weight change	☐Y ☐N
Fatigue	☐Y ☐N
Heat or cold intolerance	☐Y ☐N
Recent changes in mood	☐Y ☐N

Please include any other conditions you would like to discuss with the medical provider:

Name: _____ DOB: _____ Date: _____

4) Weight / Dieting History

Do you want to change your eating habits? ☐Y ☐N Why? _____

Have you tried to lose weight before? ☐Y ☐N How many times? _____

Are you currently on a special diet? ☐Y ☐N Specify _____

Have you used any diet programs in the past? ☐Y ☐N Which ones? _____

What was your weight at age 20? (in pounds) _____ | _____

Are members of your family overweight? Explain _____

Fill in the box of the number closest to your best estimate of servings per day

Foods with fat/cholesterol (fried foods, fatty meats, junk food)	☐0	☐1	☐2	☐3	☐4 or more
Fruits and vegetables (4 cups cooked, 1 cup raw)	☐0	☐1	☐2	☐3	☐4 or more
Caffeine (1 cup coffee, soda etc.)	☐0	☐1	☐2	☐3	☐4 or more
Calcium servings (dairy foods, 8oz. milk, yogurt, cheese, ice cream)	☐0	☐1	☐2	☐3	☐4 or more

5) Past Surgeries, Procedures & Diagnostic Tests

List past testing, hospital visits & surgeries (for example: stent, cath procedure, heart surgeries, exercise tests, heart scan, MRI, CT scan etc.)
PLEASE DO NOT WRITE "My physician has copies of all tests"

Surgery Type/Diagnostic Test	Current Problem?		Date	Physician or Hospital where prodcedure took place
Example: Brain surgery	☐Current	☑Past	May 12, 1988, May 1988	Dr. Brainsurgeon, Houston
	☐Current	☐Past		
	☐Current	☐Past		
	☐Current	☐Past		
	☐Current	☐Past		

Comments/Notes: _____

6) Allergies

List allergies & type of reaction. Include medications, food, & seasonal & environmental allergies (for example: animals, latex, smoke, etc.)

☐No Known Allergies or Never have Been Diagnosed with any Allergies

Allergy to	Description of Reaction		
Example: Peanut allergy	Hives and Rash	4.	
1.		5.	
2.		6.	
3.			

Name: _____ DOB: _____ Date: _____

7) Past & Current Medical Problems

List all medical problems for which you are currently being treated or have previously been treated
Include all diseases and illnesses you hav been told you have or are being treated for

Condition	Current Problem?		Date first diagnosed	Date when resolved or stopped taking medications or stopped being treated for
Example: Psoriasis	☑ Current	☐ Past	June 14, 1996 or June 2006	N/A or Currently being treated
Diabetes (only if taking medications)	☐ Current	☐ Past		
High Blood Pressure	☐ Current	☐ Past		
Cholesterol	☐ Current	☐ Past		
	☐ Current	☐ Past		
	☐ Current	☐ Past		
	☐ Current	☐ Past		
	☐ Current	☐ Past		

8) Medications

List type and amount of medications you use on a regular basis
Include prescription, over-the-counter, birth control, hormones, vitamins, herbs, nutritional supplements and recreational drugs

Medication	Dosage/Frequency	Reason for taking	Started (Month/Year)
Example: Aspirin	81mg once per day	Prevention	March 2005

Name: _____ DOB: _____ Date: _____

9) Family History

Please complete as much of this section as possible
You can also bring your family history with you and we will enter the information into the chart below for you

Adopted? ☐Y ☐N

Medical Condition	Father	Mother	Brother	Sister	Son	Daughter	Grandparents (PGF, PGM, MGF, MGM)	Comments
	Indicate approximate age disease first was identified							
High blood pressure	age	age	age	age	age	age	age	
High Cholesterol	age	age	age	age	age	age	age	
Diabetes (type 1 or 2)	age	age	age	age	age	age	age	
Heart Attack	age	age	age	age	age	age	age	
Heart Failure	age	age	age	age	age	age	age	
Heart surgery/stent/balloon	age	age	age	age	age	age	age	
Angina (heart pain)	age	age	age	age	age	age	age	
Leg circulation problem	age	age	age	age	age	age	age	
Failing kidneys	age	age	age	age	age	age	age	
Stroke	age	age	age	age	age	age	age	
Smoking	age	age	age	age	age	age	age	
Dementia/Alzheimer's	age	age	age	age	age	age	age	
Alcoholism	age	age	age	age	age	age	age	
Arthritis	age	age	age	age	age	age	age	
Birth Defects	age	age	age	age	age	age	age	
Hearing Problems	age	age	age	age	age	age	age	
Sudden Death	age	age	age	age	age	age	age	
Genetic Diseases	age	age	age	age	age	age	age	

Age & L=living D=deceased	Father	Mother	Brother	Sister	Son	Daughter	Grandparents PGF ____ PGM ____ MGF ____ MGM ____

*PGF = paternal grandfather; PGM = paternal grandmother; MGF = maternal grandfather; MGM = maternal grandmother

Please include any other details related to your family history or concerns you would like to discuss with our providers:

Name: _____ DOB: _____ Date: _____

10) Phase of Life - women only

Check all boxes that apply to you

Date of last menstrual period (LMP) _____

Menopause: ☐Pre-menopausal ☐Experiencing menopause ☐Other, N/A

Please include any other details related to your family history or concerns you would like to discuss with our providers:

_____

_____

_____

_____

_____

_____

11) How Did You Hear About Us?

☐Physician referral
☐Radio
☐Print advertisement
☐Television
☐Internet
☐Word of Mouth
☐Other _____

Would you like us to send your results to another health care provider? ☐Y ☐N

If so, we will need his or her first and last names and complete address:

Provider's name: _____

Clinic name: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Fax: ( ) _____

Patient Signature: X _____

We take your health history as being very important. We trust you do too!
Our clinic endeavors to offer the best care available.

Internal Purposes Only

History reviewed by: _____

Name:_____ DOB:_____ Date:_____

SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

	Chance of dozing
Sitting and reading	
Watching TV	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternon when circumstances permit	
In a car, while stopped for a few minutes in the traffic	
TOTAL	

0-10 = Normal
10-12 = Borderline
12-24 = Abnormal

Name:_____ DOB:_____ Date:_____

STRESS QUESTIONNAIRE - page 1

	Never	Seldom	Sometimes	Often	Regular
Heart pounding or racing	0	1	2	3	4
Trembling/shaking	0	1	2	3	4
Grinding of teeth (even in your sleep)	0	1	2	3	4
Do not sleep well	0	1	2	3	4
Susceptible to illness	0	1	2	3	4
Stomach pains	0	1	2	3	4
Headaches	0	1	2	3	4
Migraine headaches	0	1	2	3	4
Feeling tired constantly	0	1	2	3	4
Constipation	0	1	2	3	4
Hollow stomach	0	1	2	3	4
Lowered self-confidence	0	1	2	3	4
Loss of appetite	0	1	2	3	4
Excessive sweating (e.g. hands, face, arm pits etc.)	0	1	2	3	4
Sweaty palms	0	1	2	3	4
Listlessness - don't feel like doing stuff	0	1	2	3	4
Forget things	0	1	2	3	4
Absent-minded	0	1	2	3	4
Feeling irritated	0	1	2	3	4
Nauseous	0	1	2	3	4
Considered suicide	0	1	2	3	4
Pessimistic	0	1	2	3	4
Jealous/Envious	0	1	2	3	4
Moody	0	1	2	3	4
Pain in lower back	0	1	2	3	4
Feelings of depression	0	1	2	3	4
Anxiety	0	1	2	3	4
Loss of interest in things	0	1	2	3	4
Sensitive and/or touchy	0	1	2	3	4
Muscle pain	0	1	2	3	4
Indecisive	0	1	2	3	4
Unnecessary/excessive checking of work	0	1	2	3	4
Difficulty with breathing	0	1	2	3	4
Struggle to overcome minor illness (e.g. a cold)	0	1	2	3	4
Suspicious	0	1	2	3	4
Wasting time on irrelevant activities	0	1	2	3	4
Cannot discuss my problems with others	0	1	2	3	4
Hair loss	0	1	2	3	4
Total score:					

Name:_____ DOB:_____ Date:_____

STRESS QUESTIONNAIRE - page 2

	Never	Seldom	Sometimes	Often	Regular
Throat irritations	0	1	2	3	4
Lost sense of humor	0	1	2	3	4
Impaired concentration	0	1	2	3	4
Struggle to lose/gain weight even when following a diet	0	1	2	3	4
Heartburn	0	1	2	3	4
Skin disorders	0	1	2	3	4
Don't take the initiative you used to	0	1	2	3	4
Nightmares	0	1	2	3	4
Dry mouth	0	1	2	3	4
Consumption of energy drinks (e.g. Red Bull, 5-hour energy etc.)	0	1	2	3	4
Diarrhea	0	1	2	3	4
Nervous twitches in face and scalp	0	1	2	3	4
Feelings of inadequacy	0	1	2	3	4
Easily startled/jumpy	0	1	2	3	4
Increased appetite	0	1	2	3	4
Impaired coordination	0	1	2	3	4
Uncertainty	0	1	2	3	4
Become frustrated quickly	0	1	2	3	4
Less involvement with others	0	1	2	3	4
Biting of fingernails	0	1	2	3	4
Reduced motivation	0	1	2	3	4
Increased caffeine intake (coffee, tea, soda etc.)	0	1	2	3	4
Restlessness	0	1	2	3	4
Poor judgement	0	1	2	3	4
Increased smoking	0	1	2	3	4
Feeling out of control	0	1	2	3	4
Confused thoughts	0	1	2	3	4
Increased time sleeping	0	1	2	3	4
Use tranquilizers, sleeping pills	0	1	2	3	4
Wake up tired	0	1	2	3	4
Feeling overwhelmed by demands	0	1	2	3	4
Excessive blinking	0	1	2	3	4
Daydreaming	0	1	2	3	4
Procrastination	0	1	2	3	4
Feeling panicky	0	1	2	3	4
Difficult to identify causes of nonperformance	0	1	2	3	4
Reduced productivity	0	1	2	3	4
Total score:					

SYMPTOM SURVEY

Name: _____ DOB: _____ Date: _____

	Worse ☹				☺					*Better* ☺
Energy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mood *(depression, stress, anxiety)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Never	*Mild*	*Moderate*	*Severe*
Joint or muscle aches	☐	☐	☐	☐
Depressed mood or anxiety	☐	☐	☐	☐
Declining mental ability / focus / concentration	☐	☐	☐	☐
Mood changes / irritability	☐	☐	☐	☐
Decreased muscle strength	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐
Decreased libido / desire	☐	☐	☐	☐
Difficulty in sexual performance / climax	☐	☐	☐	☐
Rapid hair loss	☐	☐	☐	☐
Skin changes / dry or wrinkled skin	☐	☐	☐	☐
Swelling or bloating	☐	☐	☐	☐
Weight gain / unable to lose weight	☐	☐	☐	☐

Women Only:

Intimacy dryness	☐	☐	☐	☐
Hot flashes or night sweats	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐