HEART.SMART
Living to the best of your health.

WELCOME

Your Testing Is Scheduled For: Date:_____ 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 team for your appointment, so late cancellations signifcantly 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, 409-527-4041.

Need an Appointment?

Call us at 409-527-4041 to make your appointment, if we haven't already scheduled you.

Testing Location

gerstenberg.clinic
2645 Nall St,
Port Neches TX

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.

2) Clothing

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

3) Medical History

- Please fill out as much of the Patient Medical History section of the packet 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 team 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_____

Address_____ **Date of Birth**_____/_____/_____

City_____ **State**_____ **Zip**_____ **Birth Sex:** ☐ M | ☐ F

Phone #1_____ **Email Address**_____

Phone#2_____ **Opt Out of Emails:** ☐

2) Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ 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 minutes 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? ☐ N | ☐ Y - 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: ☐ N ☐ Y *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

Check any of the conditions that you currently have or have had in the past. Please explain if needed.

Cardiovascular

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

Genitourinary

- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Bladder infections
- ☐ Incontinence, dribbling
- ☐ Kidney stones
- ☐ Irregular menses (females)

Ears, Nose, Mouth

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

Endocrine

- ☐ Night sweats
- ☐ Excessive thirst

Gastrointestinal

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

Head and neck

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

Musculoskeletal

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

Skin

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

Name_____ DOB:_____ Date:_____

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Nervous breakdown
- ☐ Alcohol problems
- ☐ Physical, verbal, sexual abuse

Eyes
- ☐ Glasses or contacts
- ☐ Double, failing vision
- ☐ Dry eyes
- ☐ Pain or light sensitivity

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

Lungs
- ☐ Cough with sputum or blood
- ☐ Wheezing
- ☐ Asthma

Misc.
- ☐ Fever or chills
- ☐ Recent weight change
- ☐ Fatigue
- ☐ Heat or cold intolerance
- ☐ Recent changes in mood

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

_____

_____

_____

4) Weight History

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

Are members of your family overweight?..... ☐ **Y** | ☐ **N** Please Explain:_____

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

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."**

Check your best estimate of servings per day for each food category:

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

Comments/Notes: _____

_____

Name_____ DOB:_____ Date:_____

6) Allergies

List allergies & type of reaction (medications, food, & seasonal & environmental allergies) Ex: 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

7) 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	Started (Month/Year)
Example: Aspirin	81mg once per day	Prevention	March 2005

Name_____ DOB:_____ Date:_____

8) Family History

Please complete as much of this section as possible. Indicate approximate age disease was first identified.
You can also bring your family history with you and we will enter the information into the chart below for you.

Were you adopted? ☐ Y | ☐ N

Medical Condition	Father	Mother	Brother	Sister	Son	Daughter	Grandparents (PGF = paternal grandfather, MGF = maternal etc.)			
High Blood Pressure	Age:	Age:	Age:	Age:	Age:	Age:	PGF Age:	PGM Age:	MGF Age:	MGM Age:
High Cholesterol	Age:	Age:	Age:	Age:	Age:	Age:				
Diabetes (type 1 or 2)	Age:	Age:	Age:	Age:	Age:	Age:				
Heart Attack	Age:	Age:	Age:	Age:	Age:	Age:				
Heart Failure	Age:	Age:	Age:	Age:	Age:	Age:				
Heart surgery/stent/balloon	Age:	Age:	Age:	Age:	Age:	Age:				
Leg circulation problem	Age:	Age:	Age:	Age:	Age:	Age:				
Failing kidneys	Age:	Age:	Age:	Age:	Age:	Age:				
Stroke	Age:	Age:	Age:	Age:	Age:	Age:				
Dementia/Alzheimer's	Age:	Age:	Age:	Age:	Age:	Age:				
Alcoholism	Age:	Age:	Age:	Age:	Age:	Age:				
Arthritis	Age:	Age:	Age:	Age:	Age:	Age:				
Birth Defects	Age:	Age:	Age:	Age:	Age:	Age:				
Sudden Death	Age:	Age:	Age:	Age:	Age:	Age:				
Genetic Diseases	Age:	Age:	Age:	Age:	Age:	Age:				

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

Name_____ DOB:_____ Date:_____

11) Female Phase of Life

Date of last menstrual period (LMP) Date:_____ ☐ Menopausal ☐ Other, N/A

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

_____

_____

_____

HOW DID YOU HEAR ABOUT US?

☐ HeartSmart Screening at my place of employment
☐ My physician referred me
☐ Internet
☐ Television
☐ Print advertisement

Other_____

DO YOU NEED RESULTS FORWARDED?

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 Name:_____ Clinic Name:_____

Street Address:_____ Phone: _____

City:_____ State:_____ Zip_____ 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.

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	☐

0-9 = Typically Normal
10-12 = Borderline
13-24 = 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 (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:					

Name_____ DOB:_____ Date:_____

SYMPTOM SURVEY

	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	☐	☐	☐	☐