Bryn Mawr Medical Specialists ASSOCIATION

Bryn Mawr Medical Specialists Association
Cardiology
Bryn Mawr Medical Arts Pavilion
825 Old Lancaster Road
Bryn Mawr, PA, 19010

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________ Today's Date: ____________

Reason for visit: ______________________________

____

Allergies: ______________________________

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MEDICATIONS

Did You Bring A Medications List? ☐ **Yes** ☐ **No**

	Drug Name:	Dose:	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PAST MEDICAL HISTORY

Cardiovascular:

Condition			Condition		
High blood pressure	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Myocardial Infarction	☐ Yes	☐ No	Coronary Artery Disease	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No	If yes, date:____________		
Cardiomyopathy	☐ Yes	☐ No	If yes, date:____________		
Valvular heart disease	☐ Yes	☐ No	If yes, date:____________		
Abnormal heart rhythm	☐ Yes	☐ No	If yes, date:____________		
Ablation	☐ Yes	☐ No	If yes, date:____________		
Pacemaker	☐ Yes	☐ No	If yes, date:____________		

Past Medical History (continued)

CARDIOVASCULAR:			
	Defibrillator	☐ Yes ☐ No	If yes, date:____________________
	Echocardiogram (Echo)	☐ Yes ☐ No	If yes, date:____________________
	Stress Test	☐ Yes ☐ No	If yes, date:____________________
	Cardiac Catheterization	☐ Yes ☐ No	If yes, date:____________________
	Cardiac Stent	☐ Yes ☐ No	If yes, date:____________________
	Bypass surgery	☐ Yes ☐ No	If yes, date:____________________
	Valve replacement surgery	☐ Yes ☐ No	If yes, date:____________________
	Peripheral Vascular Disease	☐ Yes ☐ No	If yes, date:____________________
	Varicose Veins	☐ Yes ☐ No	If yes, date:____________________
	Chronic Venous Insufficiency	☐ Yes ☐ No	If yes, date:____________________
	Surgery performed?	☐ Yes ☐ No	If yes, date:____________________
	Carotid Artery Disease	☐ Yes ☐ No	If yes, date:____________________
	Surgery performed?	☐ Yes ☐ No	If yes, date:____________________
	Aneurysm	☐ Yes ☐ No	If yes, date:____________________
	Surgery Performed?	☐ Yes ☐ No	If yes, date:____________________

NEUROLOGY: ☐ Stroke/TIA ☐Seizures ☐Neuropathy

ENDOCRINE: ☐Diabetes ☐Thyroid Disorder

PULMONARY: ☐Asthma ☐COPD ☐Sleep Apnea ☐Pulmonary Embolism

GASTROINTESTINAL: ☐Ulcers ☐ GERD ☐Hiatal hernia ☐Liver Disease ☐Gallbladder Disease

KIDNEY DISEASE: ☐ Yes ☐No If yes, please state: ____________________________________

OTHER: ☐Prostate disorder ☐Erectile dysfunction ☐Breast Cancer ☐Gynecologic disorder

RHEUMATOLOGIC/MUSCULOSKELETAL DISORDER: ☐Yes ☐No If yes, please state: _________________

BLOOD DISORDER/CLOTTING DISORDER/BLOOD CLOTS: ☐Yes ☐No If yes, please state: _________________

CANCER HISTORY: ☐Yes ☐No If yes, please state: ____

Other:____
____

Surgical History

	Procedure:	Date:		Procedure:	Date:
1.	___________________________	_____________________	6.	__________________________	___________________
2.	___________________________	_____________________	7.	__________________________	___________________
3.	___________________________	_____________________	8.	__________________________	___________________
4.	___________________________	_____________________	9.	__________________________	___________________
5.	___________________________	_____________________	10.	__________________________	___________________

Social History

Have you ever smoked? ☐ Yes ☐No If yes, how many per day? ___________________________

If yes, how many years have you smoked? ________________

If yes, did you quit? ☐Yes ☐No If yes, when did you quit? ______________________________

Do you drink alcohol? ☐Yes ☐No If yes, about how many drinks per week? __________________

Do you use illicit drugs? ☐Yes ☐No If yes, what drugs? ____________________________________

What is your occupation? ____

Do you exercise? ☐Yes ☐No If yes, how do you exercise? ____________________________

If yes, how often do you exercise? ______________________

Family History

	MOTHER	FATHER	SIBLING	CHILDREN
Heart Attack / CAD: (Coronary Artery Disease)	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐
Sudden Cardiac Death: (Death <50 years old)	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐
Cardiomyopathy:	☐	☐	☐	☐
Aortic Aneurysm/Dissection:	☐	☐	☐	☐
Unexplained sudden death:	☐	☐	☐	☐
Congenital heart disease:	☐	☐	☐	☐
No Significant History:	☐	☐	☐	☐

Review of Symptoms (Check All That Apply)

☐ Fatigue	☐ Fevers	☐ Weight Change	☐Headache	☐Dizziness
☐Visual Problem	☐Hearing Difficulty	☐Sinus Congestion	☐Jaw Pain	☐Neck Pain
☐Chest Pain/discomfort		☐Heartburn	☐Passing out spells	☐Palpations
☐Cough	☐Wheezing	☐Shortness of breath	☐Nausea	☐Vomiting
☐Difficulty Swallowing	☐Frequent Urination	☐Blood in Urine	☐Blood in Stool	☐Diarrhea
☐Abdominal Pain	☐Erectile Dysfunction	☐Muscle Aches	☐Localized Numbness/Weakness	
☐Joint Aches	☐Leg Discomfort	☐Leg Swelling	☐Skin Lesions	☐ Rash

OTHER:____

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Do You Have any Particular Questions You Wanted Answered Today?

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Please arrive 15 minutes before your scheduled appointment. Thank you!