Bryn Mawr Medical Specialists Association
Cardiology
6 Lancaster Avenue, Upper Level
Wynnewood, PA 19096

PATIENT INFORMATION

Name: ____ Date of Birth: ______________________ Today's Date: __________________

Reason for visit: ____

____

Allergies: ____

____

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:						
	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 (heart ultrasound)	☐ 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:____

____

DO YOU HAVE ANY PARTICULAR QUESTIONS YOU WANTED ANSWERED TODAY?

____

____

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

Vascular Questionnaire

Have you ever been told that you have **carotid artery (neck artery) blockages**? ☐ Yes ☐ No

Have you had any **NEW vision changes** (not related to glasses)? ☐ Yes ☐ No

Have you had any **stroke-like symptoms**, such as weakness in extremities or slurred speech? ☐ Yes ☐ No

Have you had **significant leg/feet/ankle swelling**? ☐ Yes ☐ No

Do you have **varicose veins**? ☐ Yes ☐ No

Is there any **family history of abdominal aneurysm** (aortic aneurysm)? ☐ Yes ☐ No

Do you get **cramping in your legs or feet** with walking? ☐ Yes ☐ No

Do you have a **history of ulcers on your legs or feet**? ☐ Yes ☐ No

*********FOR MALE PATIENTS ONLY:*********

Are you a **male, age >65 years of age**? ☐ Yes ☐ No

Have you **smoked more than 100 cigarettes** (5 packs) TOTAL in your lifetime? ☐ Yes ☐ No

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