PATIENT: _____

DATE: _____

HISTORY OF PRESENT ILLNESS: (Location, Severity, Duration, Signs/Symptoms)

SYMPTOMS:	**YES**	**NO**	**COMMENTS**
Chest Pain	_____	_____	_____
Shortness of Breath	_____	_____	_____
Palpitations	_____	_____	_____
Leg/Foot Swelling	_____	_____	_____
Cough/Wheeze	_____	_____	_____
Dizziness	_____	_____	_____
Depression/Anxiety	_____	_____	_____
PAST HISTORY:			
Hypertension	_____	_____	_____
Diabetes	_____	_____	_____
High Cholesterol	_____	_____	_____
Heart Disease	_____	_____	_____
Other:	_____	_____	_____
FAMILY HISTORY:			
Hypertension	_____	_____	_____
Diabetes	_____	_____	_____
High Cholesterol	_____	_____	_____
Heart Disease	_____	_____	_____
PROCEDURES:			
Heart Cath	_____	_____	_____
Stent	_____	_____	_____
Bypass	_____	_____	_____
Ablation/Cardioversion	_____	_____	_____
Pacemaker	_____	_____	_____
Other:			
SOCIAL HISTORY:			
Smoking	_____	_____	_____
Drinking	_____	_____	_____

LIST CURRENT MEDICATIONS WITH TIMING/DOSAGES: