Geneva General Cardiology Associates

Patient Name: _____ Patient DOB: _____

Primary Care MD: _____ Previous Cardiologist: _____

Cardiac History	If checked, When:
□ Heart Attack	
□ Bypass Surgery	
□ Angioplasty/Stent	
□ Exercise Stress test (Treadmill)	
□ Echocardiogram (heart Ultrasound	
□ Irregular Heart Rhythm	
□ Congenital Heart Disease	
□ Heart Murmur	
□ Pacemaker	
□ Rheumatic Fever	
□ Stroke/TIA	
□ Congestive Heart Failure	

Risk Factors	When Onsent:	Risk Factors	When Onsent:
□ Hypertension		□ Bleeding problems	
□ Diabetes		□ Eye Problems	
□ Elevated Cholesterol		□ Weight Loss	
□ Kidney Disease		□ Lung Issues	
□ Thyroid Disease		□ Gastrointestinal Issues	
□ Cancer		□ Neurological	
□ Anemia		□ Stress	

Health Maintenance:

Colonoscopy: □ Never □ Yes. If Yes When:_____

Mammogram: □ Never □ Yes. If Yes When:_____

Social History:

Tobacco use: □ Present (Packs per day:_____ Cans per day:_____) □ Former (Quit Date: _____) □ Never

Exposed to second hand smoke at home? □ Past □ Present □ Never

Do you use alcohol? □ Present (Drinks per day:_____) □ Past □ Never

Social History Continued:

Do you exercise: □ Yes (Type: _____ Frequency: _____) □ No

Do you consume caffeine (coffee, tea, soda)? □ Present (Drinks per day_____) □ Past □ Never

Occupation: _____

Surgical History: Please list all past surgeries, including location and date.

1. _____
2. _____
3. _____
4. _____

Allergies: Please list all allergies and reactions

_____

_____

Family History: Please list family relation if check:

Health Problem:	**Relationship**	**Health Problem:**	**Relationship:**
□ Heart Attack		□ Kidney Disease	
□ Heart Surgery		□ Diabetes	
□ Heart Failure		□ COPD	
□ High Blood Pressure		□ Aneurysm	
□ High Cholesterol		□ Obesity	
□ Stroke/TIA		□ Varicose Veins	