

Last Name: _____ 1



THE EMORY CLINIC, INC.
1525 CLIFTON ROAD

Telephone: 404-778-2746 Fax: 404-778-2895

INITIAL CARDIOLOGY HEALTH PROFILE

MRN #: _____
To be completed by cardiology staff

DEMOGRAPHICS

Name: _____, _____, _____
(Last) (First) (M.I.)

What name do you prefer to be called by?: _____

Email address (optional): _____

Age: _____ Date of Birth: ____/____/____ M ____ F ____

Employer: _____ Appointment with Dr. _____

Current Position: _____ Appointment Date: ____/____/____

Personal Physician: (Name & Address)

Which physician referred you to us? (Name & Address)

Phone: (____) _____ - _____

Phone: (____) _____ - _____

Fax: (____) _____ - _____

Fax: (____) _____ - _____

Please sign below if you would like copies of your reports to your Primary Physician to update his/her files.

Signature: _____

Date: ____/____/____

Important Privacy Note: This form contains Private Healthcare Information and must be transmitted via secure fax to ensure confidentiality. Please fax this health history questionnaire to 1525 Emory Cardiology at 404-778-2895.

PAST MEDICAL HISTORY -

Please list any problems which you have, or have had at any time in the past. Indicate year of onset.

PROBLEM	ONSET
(1) _____	_____
(2) _____	_____
(3) _____	_____
(4) _____	_____
(5) _____	_____
(6) _____	_____
(7) _____	_____
(8) _____	_____

PREVIOUS SURGERY -

Please list any procedures you have had. Also indicate the date the procedure was performed.

PROCEDURE	DATE
(1) _____	_____
(2) _____	_____
(3) _____	_____
(4) _____	_____
(5) _____	_____

CARDIAC TESTING

Please indicate which screening procedures (if any) that you have had.

Procedure	Date	Comments
None <input type="checkbox"/>		
Stress test		
Echocardiogram		
CT Heart Cardiac Scoring/Calcium Scoring		
Cardiac Catheterization		
Other		

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FAMILY MEDICAL HISTORY			
Name	Age (Or age died)	Living/Dead	Health Issue or Cause of Death/Comments
PARENTS			
Father:			
Mother:			
SPOUSE			
Name:	<u>Sex & Age</u>		
SIBLINGS			
1.			
2.			
3.			
4.			
5.			
CHILDREN			
	<u>Sex & Age</u>		
1.			
2.			
3.			
4.			
5.			

LIFESTYLE FACTORS

1. Cigarette Use

- a. Current smoker _____ Past smoker _____ (Year quit _____) Never smoked _____
- b. Average number of packs per day: _____ c. Total number of years smoked: _____

2. Other Tobacco Use

- a. None _____ Current user _____ Past user _____ (Year quit _____)
- b. Pipe _____ Cigar _____ Smokeless _____ c. Number of years used: _____

3. Alcohol Use

- a. Average number of drinks per WEEK:
(One "drink" equals: 1 1/2 oz. liquor, 4 oz. wine, 12 oz. beer)
- 0-2: _____ 3-5: _____ 6-10: _____ 11-15: _____ 16-20: _____ 21-25: _____
26+: _____
- b. Drank in past but quit _____ (Year quit _____) Never drank _____

4. **Sleep:** Average number of hours per NIGHT: _____

5. **Work:** Average number of hours per WEEK: _____

6. **Travel:** Average number of days each MONTH: Domestic _____
International _____ Total _____

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7. Exercise and Recreation:

Which activities do you perform on a regular basis?

X	Activity:	Min. per session	Times per week:	X	Activity:	Hours per month:
	None				None	
	Walking				Golf	
	Running/Jogging				Tennis	
	Biking				Basketball	
	Swimming				Racquetball	
	Elliptical				Baseball	
	Bicycle/Cycling				Hiking	
	Stair Machine				Yardwork	
	Ski Machine				Dancing	
	Aerobics/Calisthenics				Soccer	
	Weights/Circuit Training				Football	
	Pilates				Other	
	Other					

9. Nutrition:

Please check all which apply to your current diet.

X	Current diet/Dietary Restrictions:	X	
	(Please select all that apply)		Low salt
	Regular diet - no consistent restrictions		High fiber
	Vegetarian - strict		Low carbohydrate
	Vegetarian - dairy products, eggs; no meat		Low fat - mild to moderate restriction
	No "red" meat		Low fat - severe restriction (<= 20 gm/day)
	Weight reduction		Gluten free
	Diabetic (ADA) _____ # calories/day _____		Other

SOCIAL HISTORY

1. Marital Status:

Single

Married Years married: _____ Spouse's Name: _____

Divorced

Widowed

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2. Education:

___ High School ___ College ___ Graduate Degree (Year Received _____) ___ Other

Graduate Degree: _____ Year _____

If no, highest grade achieved: _____

3. Employment

Place of employment: _____

Address: _____

Phone: (____) _____ - _____

How long have you been employed with this employer? _____

REVIEW OF SYSTEMS		
<i>Please check yes or no to each of the following symptoms which apply. If unsure, leave blank.</i>		
No	Yes	General
		Comments
		Severe fatigue
		Change in appetite
		Unexplained weight loss
		Unexplained weight gain
		Frequent trouble sleeping
Eyes, Ears, Nose and Throat		
		Double vision
		Infection in eyes
		See spots or flashing lights
		Retinal detachment
		Glaucoma
		Ringing in ears
		Hearing loss
		Loud snoring
		Hoarseness
		Pain in throat or neck
		Lumps/mass in the neck
Respiratory		
		Frequent cough
		Shortness of breath
		Change in exercise tolerance
		Wheezing
		Pneumonia
		Cough up blood
		Excessive daytime sleepiness
Cardiac		
		Chest pain/tightness/squeezing
		Chest pain or pressure with exertion
		Shortness of breath lying down
		Racing heart/palpitations
		Heart murmur
		Leg swelling
		Cramping/aching in legs with exercise
		Unexplained fainting
		History of DVT
		PE

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