Arizona Heart and Arrhythmia Clinic

New Patient Information Sheet

Name:

Today's date:

Date of Birth:

Sex:

Referring Physician/ Source

Telephone number of referring physician/ source

Fax number of referring physician/ source

Email address of referring physician/ source

Please state what medical problem brings you in today:

Current Medications: Please ALL medications both prescriptions and non-prescription

Medication name	Dose	How often	Since when
COUMADIN/WARFARIN			WHO MONITORS

Patient name:

Past Medical Problems:

Name of Medical Illness	For how long
Diabetes (Yes/ No)	
High Blood Pressure (Yes/No)	
High Cholesterol (Yes/No)	

Previous Cardiac Evaluation and Treatment:

Name of Procedure / Treatment	Yes	No	Date/Year	Which Hospital/Location
Electrocardiogram				
Echocardiogram				
Exercise Stress Test				
Coronary angiogram				
Coronary Stent				
Open Heart Surgery				
Pacemaker/ Defibrillator				

PLEASE LIST ALL YOUR MEDICATION/ FOOD/ CONTRAST ALLERGIES:

Patient name:

Personal Habits and Living status

Are you Married/ Single/ Widowed

Do you live alone at home

Do you smoke, if yes, how much

Do you drink alcohol, if yes, how much

Do you use recreational drug use, if yes, which one

What is your occupation

Family History:

Medical Illness	Father	Mother	Brother	Brother	Sister	Sister	Other
Heart Attack							
Bypass Surgery							
Angioplasty/Stent							
Sudden Death							
High Blood Pressure							
Diabetes							
High cholesterol							
Cancer							

Patient name:

Review of systems:

GENERAL

YES	**NO**	**FEVER**
YES	**NO**	**WEIGHT GAIN, WEIGHT LOSS**
YES	**NO**	**ANXIETY, DEPRESSION**

HEAD

YES	**NO**	**HEADACHE, MIGRAINE**

EYES

YES	**NO**	**PERMANENT VISION LOSS IN EITHER EYE**
YES	**NO**	**TRANSIENT VISION LOSS IN EITHER EYE**

LUNGS

YES	**NO**	**COUGH**
YES	**NO**	**BLOOD IN SPUTUM**

GASTRO-INTESTINAL

YES	**NO**	**ABDOMINAL PAIN**
YES	**NO**	**NAUSEA, VOMITTING**
YES	**NO**	**LOOSE BOWEL MOVEMENTS, DIARRHEA**
YES	**NO**	**BLOOD IN STOOL, DARK STOOLS**

YES	**NO**	**BLOOD IN VOMITING**
YES	**NO**	**CONSTIPATION**
YES	**NO**	**JAUNDICE**
YES	**NO**	**ABDOMINAL DISTENSION**

GENITO-URINARY

YES	**NO**	**DIFFICULTY IN URINATION**
YES	**NO**	**BLOOD IN URINE**
YES	**NO**	**PROSTATE CANCER**
YES	**NO**	**KIDNEY STONES**
YES	**NO**	**ABNORMAL KIDNEY FUNCTION**
YES	**NO**	**ERECTILE DYSFUNCTION**

NERVOUS SYSTEM

YES	**NO**	**WEAKNESS OR PARALYSES OF ONE SIDE OF BODY**
YES	**NO**	**LOSS OF SENSATION OF ONE SIDE OF BODY**
YES	**NO**	**ABNORMAL SPEECH**
YES	**NO**	**STROKE OR "TIA"**
YES	**NO**	**TINGLING IN HANDS AND FEET**

LEGS

YES	**NO**	**PAINFUL CRAMPS IN THIGH AND CALF ON WALKING**
YES	**NO**	**NON-HEALING ULCERS IN FEET AND LEGS**