RENO HEART INSTITUTE

PATIENT INFORMATION:

Name:_____ Date: _____

Address: _____ Date of Birth: _____

_____

Primary Phone Number: (____)_____ EMAIL: _____

Preferred Contact: ☐ Phone Call (OK to Leave Message) ☐ Text ☐ Email

Referring Provider: _____Office # (____)_____

Pharmacy:_____Pharmacy # (____)_____

YOU MAY DECLINE TO ANSWER THE FOLLOWING QUESTIONS:

Ethnicity: _____

Race: _____

Marital Status: _____

CARDIAC MEDICAL HISTORY:

- ☐ Coronary Artery Disease
  - Stent
  - Bypass Surgery
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes

- ☐ Atrial Fibrillation
- ☐ Palpitations – Racing heart, irregular heartbeat
- ☐ Dizziness or Passing Out
- ☐ Leg muscle pain with walking
- ☐ Leg swelling (New or Chronic)

PREVIOUS CARDIAC TESTING / PROCEDURE:

- ☐ Heart Catheterization
  - With Stent
  - Without Stent
- ☐ Stress Test
  - Treadmill
  - Nuclear
- ☐ Echocardiogram
- ☐ Holter Monitor

- ☐ Pacemaker
- ☐ Defibrillator / AICD
- ☐ Valve Surgery
  - OPEN SURGERY
  - TAVR
  - MITRACLIP
- ☐ Ablation / EP study

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PAST MEDICAL HISTORY:

_____
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY:

_____
_____
_____
_____
_____
_____

FAMILY HISTORY:

- ☐ Heart Attack Relative/Age:_____
- ☐ High Blood Pressure Relative/Age:_____
- ☐ High Cholesterol Relative/Age:_____
- ☐ Died Suddenly Relative/Age:_____
- ☐ Other Relative/Age:_____

SOCIAL HISTORY:

- ☐ Tobacco Use Packs/Day:_____
- ☐ Alcohol Use Amount:_____
- ☐ Recreational Drugs List: _____
- ☐ Caffeine/Energy Drinks Amount:_____
- ☐ Exercise Type/Time: _____

MEDICATIONS:

NAME OF MEDICATION	DOSE	TIMES/DAY

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MEDICATION ALLERGIES: ☐ **NO KNOWN MEDICATIONS ALLERGY**

NAME OF MEDICATIONS	REACTION
_____	_____
_____	_____
_____	_____

REVIEW OF SYMPTOMS:

GENERAL:
- ☐ Excessive Fatigue
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss

EYES / EARS / NOSE / THROAT
- ☐ Change in Vision
- ☐ Vision Loss
- ☐ Nosebleeds
- ☐ Loss of Hearing
- ☐ Poor Teeth / Tooth Pain
- ☐ Gum Bleeding

RESPIRATORY:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Productive Cough
- ☐ Difficulty Lying Flat
- ☐ Using Oxygen
- ☐ Using CPAP / BiPAP

CARDIAC:
- ☐ Chest Pain
- ☐ Racing Heartbeat
- ☐ Irregular Heartbeat
- ☐ Dizziness on Standing
- ☐ Passing Out

VASCULAR:
- ☐ Muscle pain on walking
- ☐ Poor circulation

MUSCULOSKELETAL:
- ☐ Joint Pain
- ☐ Walker
- ☐ Wheelchair

GASTROINTESTINAL:
- ☐ Nausea / Vomiting
- ☐ Bleeding in stool
- ☐ Heartburn

GENITOURINARY:
- ☐ Blood in urine

NEUROLOGICAL:
- ☐ History of Stroke / TIA
- ☐ Sudden neurological changes

HEMATOLOGICAL:
- ☐ Easy Bleeding
- ☐ Easy Bruising

ENDOCRINE:
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Cold/Heat Intolerance

PYCHOLOGICAL:
- ☐ Anxiety
- ☐ Depression

SKIN:
- ☐ Rash
- ☐ Ankle discoloration
- ☐ Varicose Veins