



Please check if you have or have not had the following.

If you do not understand a question, or if you are not sure of your answer, please place a "?" mark by the number of that part of the question.

- | | No | Yes |
|---|-----|-----|
| 1. Have you ever had: | | |
| (a) An electrocardiogram (EKG)? | [] | [] |
| (b) A chest X-ray? | [] | [] |
| (c) An echocardiogram? | [] | [] |
| (d) A treadmill or stress test? | [] | [] |
| (e) A cardiac catheterization? | [] | [] |
| (f) A temporary or permanent
pacemaker or loop recorder? | [] | [] |
| (g) A 24 hour holter monitor? | [] | [] |

If yes when & where: _____

Allergy

- | | No | Yes |
|--|-----|-----|
| 2. Are you allergic to any medications? | [] | [] |
| 3. Are you allergic to any seafood or
iodine? | [] | [] |
| 4. Are you allergic to latex? | [] | [] |
| 5. Have you ever had an allergic
reaction to I.V.P/gallbladder dye? | [] | [] |

6. Please list every drug or substance
That causes an allergic reaction:

- (a) _____
- (b) _____
- (c) _____
- (d) _____

Medications

7. Please list all medications you are currently
taking, indicate the dosage:

- (a) _____
- (b) _____
- (c) _____
- (d) _____
- (e) _____
- (f) _____
- (g) _____
- (h) _____
- (i) _____

Name: _____

Date: _____

Surgery

8. Please list all surgical procedures you have had
and their dates.

- (a) _____
- (b) _____
- (c) _____
- (d) _____

Review of Systems

9. Have you had the following?

- | | No | Yes |
|---|-----|-----|
| (a) Thyroid gland disorder? | [] | [] |
| (b) Lung, disorder such as TB,
pneumonia, asthma or COPD. | [] | [] |
| (c) Stomach ulcers or hiatal hernia | [] | [] |
| (d) Liver cirrhosis or hepatitis | [] | [] |
| (e) Kidney failure, dialysis, kidney
stones, bladder disorder. | [] | [] |
| (f) Skeletal/muscular
arthritis or bursitis | [] | [] |
| (g) Neurological disorder such as
stroke, paralysis or seizures. | [] | [] |
| (h) Cancer and where | [] | [] |
| _____ | | |
| (i) Glaucoma | [] | [] |
| (j) Other serious illness: | | |
| _____ | | |
| _____ | | |
| _____ | | |

10. Have you ever had any of the following?

- | | No | Yes |
|-------------------------------------|-----|-----|
| (a) High blood pressure? | [] | [] |
| (b) Tobacco use | [] | [] |
| How many packs per day? _____ | | |
| How many years? _____ | | |
| (c) Marijuana use | [] | [] |
| (d) Cocaine/street drug use | [] | [] |
| (e) Alcohol use | [] | [] |
| (f) Diabetes | [] | [] |
| (g) Gout | [] | [] |
| (h) High cholesterol/triglycerides | [] | [] |
| (i) Family history of heart disease | [] | [] |

(Family physician or internist)