

Name _____ Date of Birth _____

Referring Physician _____ Primary Physician _____

Cardiac Procedures (estimate most recent date)

Stress Test _____ Bypass Surgery _____
 Echo _____ Valve Repair/Replacement _____
 Heart Cath _____ Pacemaker _____
 Angioplasty/Stent _____ AICD _____

Cardiovascular History (Check all that apply)

Have you ever been told you have any of the following?

- High Blood Pressure
- Irregular/Rapid Heartbeat/Atrial fibrillation
- Palpitations
- Congestive Heart Failure
- Cardiomyopathy
- Murmur
- Coronary Artery Disease
- Do you carry Nitroglycerin? Y/N _____
- Angina
- Aneurysm/Abdominal Aortic
- Leg Cramps while walking
- High Cholesterol
- Family History of Heart Disease
- Chest Pain with or without exertion
- Shortness of Breath with or without exertion
- Stroke

Respiratory History (Check all that apply)

Have you ever been told you have any of the following?

- Asthma
- Emphysema
- Use Oxygen at home: #Liters _____
- Chronic Bronchitis
- COPD
- Sleep Apnea: Use CPAP _____
- Other _____

General History (Check all that apply)

Have you ever been told you have any of the following?

- Diabetes
 - Indigestion/GERD
 - Headaches
 - Dizziness
 - Hypo or Hyperthyroidism
 - Cancer: _____
 - Arthritis
 - Kidney Disease: _____
 - Hiatal Hernia: _____
 - Chronic Back Pain/Injury
 - Dialysis
 - Seizures
 - Degenerative Disc Disease
- Do you Smoke? Yes/No if yes # pks per day _____ if quit, approx date _____
 Do you drink alcohol? Yes/No if yes # drinks per day _____

Musculoskeletal (Check all that apply)

Yes/No Loss of Sensation in arms/legs (if yes, describe) _____
 Yes/No Joint Replacement surgery (if yes, describe) _____
 Yes/No Other orthopedic issues (if yes, describe) _____
 Do you exercise regularly? Yes/No How often? _____ Type? _____
 Height _____ Weight _____ Recent loss/gain _____

How do you learn best? (Check all that apply)

- Visual- see it
- Physical- hands on
- Logical- logic/reasoning
- Verbal (reading/say it)

