ATLANTA HEART SPECIALISTS, LLC

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MEDICAL INFORMATION SHEET

DATE: _____

Full Name: _____ Birth date/Age: _____
(First) (Middle) (Last)

Who referred you? _____ Phone_____ Fax_____

Primary Care Doctor: _____ Phone _____ Fax _____

List primary concerns relating to your heart: _____

_____

What cardiac-related tests have been done previously?

Date	Test	Where Done	Result

_____

_____

PLEASE ANSWER EACH QUESTION TO ENSURE PROPER EVALUATION AND TREATMENT

Do you have:

history of previous heart attack?	Yes	No
prior balloon angioplasty or coronary stents?	Yes	No
prior open heart surgery?	Yes	No
congestive heart failure?	Yes	No
high blood pressure?	Yes	No
high cholesterol?	Yes	No
diabetes mellitus?	Yes	No
family history of heart disease?	Yes	No

If yes, please list _____

Do you:

currently smoke cigarettes?	Yes	No
Packs per day _____ x_____ years		
If you've quit, when? _____		
drink alcohol?	Yes	No
Amt per week _____ x _____ years		
use illegal drugs?	Yes	No
Specify _____		

Are you:

allergic to shellfish?	Yes	No
sensitive to IV dyes?	Yes	No
sensitive/allergic to medications?	Yes	No

Please list allergies or sensitivities below:

_____

_____

MEDICAL INFORMATION SHEET (Continued)

Please list all medications, herbs, and vitamins that you are currently taking:

Medicine/Herb	Dose (mg)	Frequency	Medicine/Herb	Dose (mg)	Frequency

Please list all medical problems

Please list all previous surgeries (with date & place)

Do you get chest pressure, pain, or discomfort?	Yes	No
Do you take Nitroglycerin for chest discomfort?	Yes	No
Do you ever get short of breath?	Yes	No
Is your breathing worse while lying down?	Yes	No
Do you get palpitations, heart racing or skipped heartbeats?	Yes	No
Do you get swelling in your legs or feet?	Yes	No
Do you get pain in your legs when you walk?	Yes	No
Do you feel dizzy or lightheaded?	Yes	No
Have you passed out/fainted recently?	Yes	No
Have you had fever/chills recently?	Yes	No
Have you had weight loss recently?	Yes	No
Have you had headaches recently?	Yes	No
Have you had dark or bloody stools recently?	Yes	No
Do you snore?	Yes	No
Do you feel weak or get tired easily?	Yes	No

Please specify any physical limitations _____

_____

Please check appropriate boxes: ☐ Single ☐ Married ☐ Divorced

☐ Employed ☐ Unemployed ☐ Disabled

Where do you work? _____ Phone: _____

What type of work do you do? _____

Ethnicity: _____ Language: _____ Race:_____

Please give your home phone number and one additional contact name and number:

Home: _____ Additional: _____