HCAVa Cardiology Associates of Richmond
An HCA affiliate

**Name:** _____ **Reason for visit**:_____

**PCP**: _____ **Pharmacy:** _____

**Do you have or have you been treated for: (Circle all that apply)**

Chest Pain  Heart Attack  High Blood Pressure  High Cholesterol  Diabetes  Stroke  COPD

Carotid Disease  Heart Failure  Heart Valve Problem  Heart Murmur  Rheumatic Fever

Heart Rhythm Problem  Vascular Disease  Asthma  Tuberculosis  Anemia  Blood Disorder

Stomach Ulcer  Heartburn/Reflux  Thyroid Problem  Kidney Disease  Gallbladder

Hepatitis  Arthritis  Sleep Apnea  Seizures  Cancer date: _____ Site: _____

Other: _____

**Please List Surgeries: (Give location and date)**

_____

_____

**Have you ever had any of the following heart tests? (Give location and date)**

Cardiac Catheterization _____ Stress Test (exercise test): _____

Echocardiogram: _____ Stress Echocardiogram: _____

Nuclear Stress Test: _____ Holter Monitor (24/48 hrs.) or Event Monitor (30 days):_____

**Habits:** Do you smoke? ☐ Yes ☐No How many years? _____ Packs Daily: _____ Interested in quitting? ☐ Yes ☐No
Did you ever smoke? ☐ Yes ☐No How many years? _____ Packs Daily: _____ When did you quit? _____
How much alcohol do you drink? _____ day _____ week _____ month _____ year
How many caffeinated drinks do you drink? (Coffee, tea, soda) _____day _____week

Are you **allergic** to any medications? ☐ Yes ☐No, please list: _____

**Circle all that you are allergic to**: Dye used for X-rays (IV dye)  Adhesive Tape  Latex  Shell Fish

| **Family History** | Living | Age | Heart Problem | High Blood Pressure | High Cholesterol | Stroke | Diabetes | Cancer |
|---|---|---|---|---|---|---|---|---|
| Father | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brother(s) | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sister(s) | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Paternal Grandpa | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Paternal Grandma | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Maternal Grandpa | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Maternal Grandma | ☐Y ☐N | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

# Medications:

include vitamins, herbal supplements, and over the counter mediations

| Name | Dose | How many times a day? |
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