



Ablation, Lead Extraction, P.M., FGD, BRJ
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Patient Name: _____

Date of Birth: _____

In one sentence, please describe your expectation(s) of today's visit: _____

Description of Main Symptoms (reason for today's visit)	When did it start?
1.	
2.	
Previous Cardiac Surgeries/Procedures:	

Other Cardiologists seen in the past: _____

Other Past or Present Medical Conditions	When diagnosed?
1.	
2.	
3.	
4.	
5.	
6.	

Previous Surgeries	Surgeon	Hospital	Date
1.			
2.			
3.			
4.			

Allergy: _____

Medications You're Taking	Dosage (mg)	How many times/day?	Date started
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Social History:

Smoking? Yes/No # Packs per day _____ When started _____ When quit _____

Alcohol? Yes/No How much? _____ Caffeinated drinks? _____

Substance abuse history: _____

Marital status (circle one): Single/Married / Widowed / Divorced / Separated

Where were you born? _____

What language(s) do you speak? _____

What do you do (occupation)? _____

Family History:

Relatives	Age	Alive or Deceased	Medical Conditions
Father		A / D	
Mother		A / D	
Brothers		A / D	
		A / D	
Sisters		A / D	
		A / D	
Children		A / D	
		A / D	

Review of System (please check all that apply):

Cardiovascular:

<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Heart attack
<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Enlarged heart
<input type="checkbox"/>	Palpitation	<input type="checkbox"/>	Ankle swelling	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Short of breath at night	<input type="checkbox"/>	Sleep on 2+ pillow	<input type="checkbox"/>	Chest injury
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	High triglycerides	<input type="checkbox"/>	Diabetes

Lung:

<input type="checkbox"/>	Cough (dry)	<input type="checkbox"/>	Sputum/Phlegm	<input type="checkbox"/>	Bloody Phlegm
<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Abnormal Chest XR	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	Pneumonia

Urinary System:

<input type="checkbox"/>	Prostate disease	<input type="checkbox"/>	Awaken to urinate	<input type="checkbox"/>	Difficulty urinating
<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	Bloody urination	<input type="checkbox"/>	Kidney infection
<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	Pus in urine	<input type="checkbox"/>	

Abdominal Problems:

<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Heart burn
<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Abnormal Chest XR	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	Pneumonia

Nervous System Problems:

	Fainting		Dizziness		Vertigo
	Lightheadedness		Headaches		Head injury
	Stroke		Paralysis		Convulsions
	Epilepsy		Loss of vision		Double vision
	Loss of sensation		Loss of strength		Loss of coordination

Other Problems:

	Gout		Thyroid disease		Varicose veins
	Blood clots		Leg pain with walking		Arthritis
	Rheumatism		Joint pains		Joint swelling
	Rash		Syphilis		Easy bleeding

This form was filled out by:

- You (the patient)
 Your spouse
 A friend

Patient signature _____

Date ____/____/____