CAROLINA CARDIOLOGY ASSOCIATES

Name: _____ Date of Birth: _____

Do you have any of the following conditions?

High Blood Pressure_____ High Cholesterol_____ Diabetes_____

Coronary Artery Disease_____ Peripheral Vascular Disease_____

Have you ever had any of the following?

Nuclear Stress Test_____ Echo (heart ultrasound)_____

Angioplasty_____ Heart Cath_____

Open Heart Surgery_____ Stroke_____

Hiatal Hernia_____ Ulcer_____

Please list any past surgeries performed?

_____ _____

_____ _____

How far can you walk?

Feet_____ Blocks_____ Miles_____ Unlimited_____

What limits your ability to walk further?_____

Have you ever smoked?_____ Do you smoke now?_____

Do you drink alcohol?_____

Any other medical problems?

_____ _____

_____ _____

Have you recently been in the hospital or ER? Yes / No

If so which hospital were you seen? _____

Approximate date you were seen: _____