

MID AMERICA HEART, P.C.

Patient Assessment for Office Procedures

Name: _____ Age: _____ Ht. _____ Wt. _____

Referring Physician: _____ Date: _____

Reason for Exam: _____

Patient is able to walk on a treadmill: Yes No Consent signed: Yes No

Patient exercises regularly: Yes No If yes how often: _____

Drug Allergies: _____

Symptoms:

Chest Discomfort: Yes No
Describe - Aching Burning Dull Pain
Pressure Sharp Other_____
Site - Lt. / Rt. Side Lt/ Rt. Arm Neck
Jaw Between Shoulders Midsternall

Dizziness: Yes No
Edema: Yes No
Site - ankle legs hands Other_____
Palpitations: Yes No
Shortness of Breath Yes No

Other Medical Conditions:

Medical History:

A- Fib Yes No
Aortic Stenosis Yes No
Carotid Stenosis Yes No
Cholesterol Yes No
COPD Yes No
CAD Yes No
Family Hx Yes No
Who _____
CATH Yes No
Date: _____
CABG Yes No
Date: _____
Diabetes Yes No
Emphysema Yes No
Heart Attack Yes No
Date: _____
Hypertension Yes No
Pre- OP Clearance Yes No
PVD Yes No
Smoke Yes No

Medications:

Surgeries:

