Cardiology Wellness Center: Follow Up Visit Hal M. Roseman, MD, MPH, FACC, FACP

Name:	**Age:**	**Birth date:** **Social Security Number:**
Family Doctor:	**Sex:**	**Date:**
Email:		

I. Why are you seeing the cardiologist today?

LIST and DESCRIBE any symptoms, problems, or concerns. Indicate the date you first noticed these problems.

DESCRIBE what you want or expect from today's visit?

_____

_____

II. Since your last visit, have you diagnosed, treated, or *tested* by other health care facilities or personnel for any new medical problems? ☐ Yes, ☐ No.

If so, please Describe?

_____

III. Medical symptom list: Since your last visit, have you developed any *new* symptoms or medical conditions? Check only, if yes

☐	Recurrent Headaches	☐	Frequent Heartburn	☐	Poor control of urination
☐	Cataracts / Glaucoma	☐	Diarrhea or Constipation	☐	Prostate problems
☐	Frequent sore throat, flu, or colds	☐	Stomach Problems: bloating, indigestion, poor digestion	☐	Arthritis/ Joint and Muscle Aches
☐	Vision problems	☐	Gallbladder problems	☐	Gout
☐	Sinus allergy / Hay fever	☐	Hepatitis / Jaundice	☐	Swelling of ankle, feet, or legs
☐	Dizziness and/or Vertigo	☐	Diverticulitis	☐	Fainting or passing out
☐	Hearing difficulty	☐	Appetite Change / Anorexia	☐	Dizziness
☐	Head or neck injury	☐	Erectile Dysfunction	☐	Cancer/ Tumors
☐	Thyroid problems	☐	Recurrent back or leg pain	☐	Insomnia
☐	Cough or Sputum Production	☐	Anemia	☐	Fatigue or lack of energy
☐	Bronchitis	☐	Bleeding abnormality	☐	Anxiety/ Panic Attacks
☐	Emphysema	☐	Blood clots	☐	Depression
☐	Asthma	☐	Bladder / kidney problems	☐	Unusual weight loss or gain

Explain any items you checked: How long you have had any of these symptoms? Have you ever been evaluated for these symptoms?

_____

How would you rate your current physical conditioning and ability to exercise: ☐Excellent condition ☐Good Condition ☐Fair Condition ☐Poor Condition? How far can you walk without getting short of breath? _____ (_____ blocks, _____ feet)

How many flights of stairs (approximately ten steps per flight) can you walk before getting short of breath? _____ or before stopping? _____

Have you been experiencing any of the following symptoms?

1	Shortness of breath	☐Yes	☐No
2	Swelling of your legs	☐Yes	☐No
3	Dizziness	☐Yes	☐No
4	Palpitations	☐Yes	☐No
5	Chest discomfort, pressure	☐Yes	☐No
6	Leg pain	☐Yes	☐No

IV. Since your last visit, have you ☐ been hospitalized, ☐ suffered any injuries, or ☐ undergone any surgeries? ☐ Yes, ☐ No. If so, please DESCRIBE with dates of the events.

_____

V. Since your last visit, are you aware of any new ALLERGIES, either to any drugs, medications, food, latex, tape etc.

_____

VI. Social History and Habits: Since your last visit, are you aware of any new changes in any of your life situations described below?

Marital Status: ☐Married, ☐Separated, ☐Divorced, ☐Widowed, ☐Single
Do you currently smoke cigarettes or use any tobacco products? ☐Yes (_____ packs a day);
☐ No (When did you quit? _____ years)

Do you drink regularly any of the following?

1. Coffee or Tea: ☐No ☐Yes _____ cups or glasses a day
2. Soda/cokes: ☐No ☐Yes _____ servings a day
3. Beer: ☐No ☐Yes _____ cans/bottles (☐8, ☐12, ☐16 oz) a week
4. Wine: ☐No ☐Yes _____ glasses a week (3 ounce glasses)
5. Liquors: ☐No ☐Yes _____ numbers of drinks (1.5 ounce per drink) a week

Exercise History:
Do you perform routine exercise? ☐Yes, ☐No.
Yes, how often? _____ times per week. How long are your exercise sessions? _____ minutes.
What kind of exercises? ☐ bicycling, ☐running, ☐walking, ☐calisthenics and stretching, ☐water aerobics, ☐ weight lifting and body toning, ☐dancing, ☐ golf, ☐ other: _____.

VII. Family History

Since your last visit, has anyone in your family died or developed any new medical conditions: stroke or TIA, heart attack, cancer, diabetes, peripheral vascular disease**? ☐ No, ☐ Yes, please explain:** _____