Kenneth P. Tway
MD, FACC

Excellence in the art and science of healing the heart.

Background

Name:_____ Date of Birth:_____ Today's Date:_____

Primary Care Physician:_____

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other: _____

☐ Retired Most Recent/Current Occupation:_____ Exercise: _____

Cardiac Risk Factors (Check all that apply)

☐ Hypertension (High blood pressure) ☐ High Cholesterol ☐ Overweight/Obesity

Tobacco (packs per day) ☐ Never ☐ <½ ☐ ½-1 ☐ 1-2 ☐ >2 ☐ Quit Smoking Date:_____

Alcohol (drinks per day): ☐ None ☐ <1 ☐1-2 ☐2-3 ☐ >3 ☐Quit Alcohol Date: _____

Caffeine (drinks per day): ☐ None ☐ <1 ☐1-2 ☐2-3 ☐ >3

Personal Past Cardiac History (Check all that apply)

☐ ***Coronary Artery Disease*** ☐ Myocardial Infarction (Heart Attack) ☐ Angina

Most Recent Heart Catheterization (Date & Hospital) _____

☐ Coronary Stents (Dates) _____ ☐ Angioplasty (Dates) _____

☐ Cardiac Bypass Surgery (Date) _____ ☐ Last Stress Test (Date/Place) _____

☐ ***Congestive Heart Failure*** Last Hospitalization for Heart Failure (Date & Hospital) _____

Most Recent Echocardiogram (Date & Location): _____ Ejection Fraction: _____

☐ ***Peripheral Vascular Disease*** ☐ Stroke ☐ Transient Ischemic Attack (Mini Stroke) ☐ Carotid artery disease

☐ Abdominal Aortic Aneurysm ☐ Leg Claudication (Pain with walking)

☐ Vascular Surgery (type, date, place) _____

Other: _____

Valvular Heart Disease Aortic Valve: ☐ Stenosis ☐ Regurgitation

Mitral Valve: ☐ Prolapse ☐ Regurgitation ☐ Stenosis ☐ Rheumatic Fever

☐ Valve Surgery (Type of Valve, Date, Hospital): _____

Other: _____

Heart Rhythm Disorder ☐ Palpitations ☐ Atrial Fibrillation ☐ Atrial Flutter ☐ WPW

☐ Heart Block ☐ Syncope (passing out) ☐ Pacemaker (Type, date) _____

☐ Ablation Procedure (Type, Date, Hospital): _____

Other Cardiac Disease ☐ Myocarditis ☐ Pericarditis ☐ Pericardial Effusion ☐ Pulmonary Hypertension

☐ Other: _____

Personal Past Medical History (Please check conditions currently treated or treated in the past)\

Lung disease:	☐ Asthma ☐ COPD or emphysema ☐ Sarcoid disease
	☐ Sleep Apnea ☐ CPAP use ☐ Pneumonia
Neurological diseases:	☐ Migraine headaches ☐ Seizure disorder ☐ Neuropathy
Liver disease:	☐ Hepatitis ☐ Liver failure (cirrhosis) ☐ Gallstones
Gastrointestinal disease:	☐ Gastroesophageal reflux disease (heartburn) ☐ Peptic ulcer disease
	☐ Chronic diarrhea ☐ Constipation ☐ Irritable bowel syndrome
Kidney disease:	☐ Renal failure ☐ hemodialysis or Peritoneal dialysis
Autoimmune disease:	☐ Osteoarthritis ☐ Gout ☐ Rheumatoid arthritis ☐ Lupus arthritis
	☐ Scleroderma ☐ Immune deficiency (HIV, AIDS, or other)
Hematologic disease:	☐ Anemia ☐ Bleeding disorder ☐ Deep Vein thrombosis (DVT)
	☐ Pulmonary embolus (PE)
Oncologic disease:	☐ Cancer (type) _____
Cancer treatments:	☐ Chemotherapy ☐ Radiation ☐ Surgery
Endocrine disease	☐ Thyroid disease ☐ Cushing's disease ☐ Addison's disease
Ophthalmologic disease	☐ Glaucoma ☐ Cataracts ☐ Macular degeneration
Psychiatric:	☐ Depression ☐ Anxiety ☐ Other: _____

Other Personal Medical History

_____ _____ _____ _____

_____ _____ _____ _____

Personal Past Surgical History (Please list type of surgery, approximate year)

☐ Gallbladder _____ ☐ Appendix _____ ☐ Tonsils _____ ☐ Hernia _____

Surgery	***Year***	***Surgery***	***Year***

Medication Allergies: _____

Current Medications You may attach a separate list. Include herbal remedies, aspirin, and vitamin supplements.

Medication	***Dose***	***How often***

Family History (Please list immediate family members –parents, siblings, children)

	Deceased	Age (if Deceased, age at death)	Heart attack	Heart Failure	Heart Bypass Surgery	Hypertension	Stroke	Other
Father	☐	______	☐	☐	☐	☐	☐	________
Mother	☐	______	☐	☐	☐	☐	☐	________
____________	☐	______	☐	☐	☐	☐	☐	________
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____________	☐	______	☐	☐	☐	☐	☐	________

Review of symptoms: Please check any symptoms you have had in the past 3 months

General:
- ☐ Change in appetite
- ☐ Persistent fever
- ☐ General fatigue
- ☐ General weakness
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Anxiety
- ☐ Depression

Eyes:
- ☐ Blurry vision
- ☐ Loss of vision
- ☐ Dry eyes

Ears, nose, mouth, throat:
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Nosebleeds
- ☐ Dentures
- ☐ Sore throat
- ☐ Hoarseness

Cardiovascular:
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Fainting/loss of consciousness
- ☐ Blue fingers or lips
- ☐ Varicose Veins

Respiratory:
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Short of breath laying down

Endocrine:
- ☐ Adrenal disease
- ☐ Cortisone treatment

Genitourinary:
- ☐ Frequent daytime urination
- ☐ Frequent nighttime urination
- ☐ Pain or burning with urination
- ☐ (men) erectile dysfunction

Nervous system:
- ☐ Headaches
- ☐ Lightheadedness/dizziness
- ☐ Adrenal disease
- ☐ Memory loss

Gastrointestinal:
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Tarry stools
- ☐ Jaundice
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Difficulty swallowing

Skin:
- ☐ Rash
- ☐ Loss of pigmentation
- ☐ Itching
- ☐ Dry skin
- ☐ Easy bruising

Musculoskeletal:
- ☐ Muscle cramps
- ☐ Pain in joints
- ☐ Swollen joints
- ☐ Stiffness