

**WELCOME TO COLUMBIA CARDIOLOGY ASSOCIATES, LTD.**  
**PLEASE TAKE A FEW MINUTES TO COMPLETE THE FOLLOWING FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

What pharmacy do you use? Name/location/phone: \_\_\_\_\_

**SOCIAL HISTORY**

Marital status:      Single              Married              Divorced              Widowed

Number of children: \_\_\_\_\_

Are you currently employed?    Yes    No

Current or past occupation: \_\_\_\_\_

If retired, when did you retire? \_\_\_\_\_

**SMOKING / DRUGS**

Do you smoke?    Yes    No    Quit

Cigarettes per day? \_\_\_\_\_ For how long? \_\_\_\_\_

If quit, how long ago did you quit? \_\_\_\_\_

What do you smoke?    Cigarettes    Cigars    Pipe    Other: \_\_\_\_\_

Do you use any recreational drugs?    Yes    No    Specify: \_\_\_\_\_

**ALCOHOL / BEVERAGES**

Do you drink alcohol?    Yes    No

If yes, estimate amount per week: \_\_\_\_\_

Have you ever had a problem with heavy use of alcohol?

Yes    No    When: \_\_\_\_\_

How many caffeinated beverages (coffee, tea, cola) do you drink each day? \_\_\_\_\_

**EXERCISE**

Do you exercise?    Yes    No

How many times per week? \_\_\_\_\_

What kind of exercise? \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Is your father alive?    Yes (age \_\_\_\_\_)    No (age \_\_\_\_\_)    Cause of death: \_\_\_\_\_

Is your mother alive?    Yes (age \_\_\_\_\_)    No (age \_\_\_\_\_)    Cause of death: \_\_\_\_\_

How many brothers do you have? \_\_\_\_\_ How many sisters do you have? \_\_\_\_\_

Has any parent or sibling been diagnosed with heart disease before the age of 65?    Yes    No

**VASCULAR SCREENING**

1. Do you ever get pain or discomfort in your legs while you walk?              Yes    No    (If yes, please continue)
- A. Does this pain ever begin when you are standing or sitting?              Yes    No
- B. Do you get it if you walk uphill or hurry?              Yes    No
- C. Do you get it when you walk at an ordinary pace or on level ground?    Yes    No
- D. What happens when you stop walking? (please circle one)
- Pain continues for more than 10 minutes
  - Pain disappears in 10 minutes or less

(Continued on back)

Have you **EVER** had the following health problems: (please explain if needed)

Circle One

Cancer	Yes	No	_____
Stroke	Yes	No	_____
Heart Attack	Yes	No	_____
Rheumatic Fever	Yes	No	_____
Diabetes	Yes	No	_____
High Cholesterol	Yes	No	_____
High Blood Pressure	Yes	No	_____
Hepatitis/Liver Disease	Yes	No	_____
HIV/AIDS	Yes	No	_____
Glaucoma	Yes	No	_____
Cataracts	Yes	No	_____
Anemia	Yes	No	_____
Arthritis	Yes	No	_____
Thyroid Disorder	Yes	No	_____
Asthma	Yes	No	_____
Emphysema	Yes	No	_____

Have you had any of the following **IN THE LAST MONTH:**

Chest Pain	Yes	No	_____
Palpitations	Yes	No	_____
Feet Swelling	Yes	No	_____
Shortness of Breath	Yes	No	_____
Wheezing	Yes	No	_____
Snoring	Yes	No	_____
Cough	Yes	No	_____
Fever	Yes	No	_____
Weight Loss or Weight Gain	Yes	No	_____
Blurred Vision	Yes	No	_____
Rash	Yes	No	_____
Itching	Yes	No	_____
Other Skin Problems	Yes	No	_____
Hearing Difficulty	Yes	No	_____
Difficulty Swallowing	Yes	No	_____
Nose Bleeds	Yes	No	_____
Easy Bruising	Yes	No	_____
Swollen/Tender Lymph Nodes	Yes	No	_____
Seasonal Allergies	Yes	No	_____
Excessive Thirst	Yes	No	_____
Muscle Pain	Yes	No	_____
Swollen Joints	Yes	No	_____
Incontinence	Yes	No	_____
Difficulty Starting Urinary Flow	Yes	No	_____
Constipation	Yes	No	_____
Nausea or Vomiting	Yes	No	_____
Bloody Stools	Yes	No	_____
Diarrhea	Yes	No	_____
Loss of Consciousness	Yes	No	_____
Seizures	Yes	No	_____
Numbness/Tingling in Extremities	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____