920-433-3640 • 1-800-472-3242
744 South Webster Ave.
Green Bay, WI 54301

CARDIOVASCULAR HEALTH PROFILE

Name: ____**DOB:** __________________

Date: _________________ **Referred by:** ________________________________

HEALTH HISTORY
Please list all past/current health problems:

____
____
____
____

Please list all surgeries and the month/year they were done:

____
____
____

Do you or any members of your family have or had any of the following:

	You	Mother	Father	Brother(s)	Sister(s)	Other
Heart Attack	Age:	Age:	Age:	Age:	Age:	Age:
Stroke or TIA	Age:	Age:	Age:	Age:	Age:	Age:
Coronary artery bypass	Age:	Age:	Age:	Age:	Age:	Age:
Congestive heart failure	Age:	Age:	Age:	Age:	Age:	Age:
Angioplasty (balloon)/Stent	Age:	Age:	Age:	Age:	Age:	Age:
Heart rhythm problems	Age:	Age:	Age:	Age:	Age:	Age:
High cholesterol	Age:	Age:	Age:	Age:	Age:	Age:
High blood pressure	Age:	Age:	Age:	Age:	Age:	Age:
Blockage of an artery in: arms, legs, neck or abdomen	Age:	Age:	Age:	Age:	Age:	Age:
Sudden death at age 40 or younger	Age:	Age:	Age:	Age:	Age:	Age:

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SOCIAL HISTORY

Smoking:
❒ Current ❒ Previous-when quit? ___________________ ❒ Never
Years smoked? ______________
How much per day? _________________ ❒ Cigarettes ❒ Cigars ❒ Pipe

Alcohol:
Do you drink alcohol? ❒ Yes ❒ No ❒ Recovering
If yes, what and how much per day/week? _______________________________________

Drug use:
Use of illicit street drugs? ❒ Current ❒ Previous ❒ Never ❒ Recovering
If previous or current use, what? ____

Exercise:
Do you exercise regularly (swim, walk, run, bike, etc.)? ❒ Yes ❒ No
What do you do? ____
How many minutes? _________________ How many times per week? ________________

Marital Status:
❒ Single ❒ Divorced ❒ Married ❒ Widowed

Occupation:
❒ Employed ❒ Unemployed ❒ Retired ❒ Disabled ❒ Student
Occupation: ____

ALLERGIES

Please list all non-medication and medication allergies and medication intolerances:
____
____
____
____

VACCINATIONS Please list the most recent with month/year.

Influenza vaccination: ________________ Pneumonia vaccination: _________________

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MEDICATIONS

Please list all prescribed and over the counter (vitamins, herbs, etc) medications:

NAME	DOSE	FREQUENCY OF USE

*****Please bring all prescribed and over the counter (vitamins, herbs, etc) medications to your appointment.**

REVIEW OF SYSTEMS (Check all that apply)

General:

❒ Fever ❒ Chills ❒ Sweats ❒ Fatigue ❒ Weight loss
❒ Weight gain ❒ Appetite loss

Eyes:

❒ Blurred vision ❒ Double vision ❒ Eye pain ❒ Eye discharge
❒ Eye redness/irritation ❒ Corrective lenses ❒ Glaucoma ❒Cataracts

Ears/Nose/Throat:

❒ Poor hearing ❒ Earache ❒ Sore throat ❒ Pain/difficulty swallowing
❒ Ringing in ears ❒ Nose bleeds ❒ Hoarseness ❒ Dental infection

Cardiovascular:

❒ Palpitations ❒ Lightheadedness ❒ Swelling of legs/feet
❒ Chest discomfort ❒ Fainting/passing out ❒ Leg cramps with exertion
❒ Waking at night short of breath ❒ Difficulty breathing lying flat

Respiratory:

❒ Asthma ❒ Wheezing ❒ Excessive sputum ❒ Coughing up blood
❒ Cough ❒ Loud snoring ❒ COPD/emphysema ❒ Shortness of breath

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Gastrointestinal:
❒ Abdominal pain ❒ Diarrhea ❒ Rectal bleeding ❒ Nausea
❒ Dark tarry stools ❒ Vomiting ❒ Constipation ❒ Hemorrhoids

Genitourinary:
❒ Pain with urination ❒ Incontinence ❒ Frequent urination at night
❒ Erectile dysfunction ❒ Blood in urine
Females only: ❒ Missed periods ❒ Post menopause ❒ Excessively heavy periods

Musculoskeletal:
❒ Arthritis ❒ Joint stiffness/swelling ❒ Muscle weakness ❒ Gout

Skin:
❒ Open sores ❒ Dryness ❒ Itching ❒ Rash ❒ Nodules

Neurologic:
❒ Numbness/tingling ❒ Dizziness/vertigo ❒ Headaches ❒ Seizures
❒ Memory loss ❒ Weakness ❒ Tremors

Psychiatric:
❒ Anxiety ❒ Depression ❒ Insomnia ❒ Suicidal thoughts

Endocrine:
❒ Cold intolerance ❒ Heat intolerance ❒ Excessive thirst ❒ Thyroid disease

Hematologic/Lymphatic:
❒ Abnormal bleeding ❒ Abnormal bruising ❒ Enlarged lymph nodes

Allergic/Immunologic:
❒ Hives ❒ Food allergies ❒ Hay fever/seasonal allergies
❒ Frequent infections ❒ HIV exposure

SECTION TO BE COMPLETED BY PROVIDER

Physical:
Height: __________ Weight: __________ BMI: __________ Waist Circumference: ____________________
B/P right arm: ______________________________ B/P left arm: ______________________________
Carotid bruits: _______________ Complete Pulse: DP/DT: _______________
Femoral: _______________
Radial: _______________
Carotid: _______________
Heart auscultation: ____
Lungs auscultation: ____

Risk Factors:
❒Smoking ❒ ETOH ❒ Weight ❒ Stress ❒ HTN
❒ Dyslipidemia ❒Renal failure ❒ Fm Hx heart disease ❒ Inactivity ❒ DM