Heart Masters Medical Associates
Clinical Intake Form

Please check any of the following that apply to you:

□ Heart attack	□ High cholesterol
□ High blood pressure	□ Diabetes type 1 or type 2
□ Stroke	□ Heart Murmur
□ Abnormal heart rhythm (arrhythmia)	□ Palpitations or irregular heartbeats
□ Enlarged heart	□ Congestive heart failure
□ cancer	□ COPD
□ CAD (coronary artery disease)	□ PVD (pulmonary valve disorder)
□	□

Cardiac Surgeries & Procedure		**Other Surgeries & Procedures**	
□ Cardiac Cath	Year	□ Appendectomy	year
□ Stress test	Year	□ Back surgery	Year
□ Echocardiogram	Year	□ Cholecystectomy (Gallbladder removed)	Year
□ EKG: Electrocardiogram	Year	□ Gastric bypass	Year
□ Coronary Angioplasty	Year	□ Hysterectomy	Year
□ Stent placement	Year	□ Knee surgery	Year
□ Coronary bypass surgery	Year	□ Mastectomy	Year
□ Heart Valve repair/Replaced surgery	Year	□ Nephrectomy (Kidney removed)	Year
□ Electrophysiology study	Year	□ Tonsillectomy	Year
□ Pacemaker implant	Year	□ Thyroidectomy	Year
□ Cardioversion	Year	□	
□ ICD placement	Year		

SOCIAL & FAMILY HISTORY

Marital Status: M ☐ W ☐ S ☐ D ☐ **Children**: Yes ☐ No ☐ **How many?** Boys: _____ Girls: ____

Tobacco use: Current ☐ **How many?** _____ Per day/Week Never ☐Former ☐Year quit: _____ Age started: ____ Age stopped? ____

Alcohol: Current ☐ Never ☐ Former ☐ Year quit: _____ **Frequency**: Daily ☐ Frequent ☐ Occasional ☐ Rarely ☐ Socially ☐

Exposed to 2nd hand smoke? ☐ Y ☐ N Allergies to any medications or food? _____

Caffeine Use: Y N **Types:** ☐Chocolate ☐Coffee ☐Soda ☐Tablets ☐ Tea ☐ Energy drinks **Caffeine per day**: _____ daily

HEALTH HABITS:

Activity level? □ Moderate □ Sedentary □ Vigorous
Do you exercise? Y N What type/ _____ /how often?_____ times/week
Diet History or eating habits? □ Healthy □Low sodium intake □Fast food □ Fried food intake □ Diabetic diet □ Vegetarian □ Vegan
Do you consider your self to be a risk of falling down? Yes or No **Any fall in the last year?** Y N How many? _____
Did the fall(s) result in injury? Y N Treatment: _____

FAMILY HISTORY

Relationship	Circle One	Conditions/Diagnosis	Conditions/Diagnosis	Cause of death	Age at death
Father	Alive & well / Deceased				
Mother	Alive & well / Deceased				
Brother	Alive & well / Deceased				
Sister	Alive & well / Deceased				
Maternal Grandmother	Alive & well / Deceased				
Maternal grandfather	Alive & well / Deceased				
Paternal Grandfather	Alive & well / Deceased				
Paternal Grandmother	Alive & well / Deceased				