SHERVIN ESHAGHIAN, M.D.

ATTENDING CARDIOLOGIST, CEDARS-SINAI HEART INSTITUTE
ASSOCIATE CLINICAL PROFESSOR, DAVID GEFFEN SCHOOL OF MEDICINE
CEDARS-SINAI HEART INSTITUTE

RANKED #1 HEART PROGRAM IN THE WEST, USN&WR 2013-2015

NAME (Last Name, First Name, M): _____ **DATE:** _____

REFERRING PHYCIAN_____ **PRIMARY CARE PHYSICIAN**_____

AGE: _____ **DATE OF BIRTH:** _____ **SEX**: M F

HEIGHT: ____FT, ___IN **WEIGHT**: _____ lbs

Why are you here to see the Cardiologist (heart doctor)?

_____

_____

_____

Check off any heart symptoms:

__Heart attack
__Angina
__Chest pain or Pressure
__Shortness of breath
__ Heart murmur
__Abnormal rhythm (Arrhythmia)
__Palpitations/irregular heart beats
__Fainting
__Leg cramps when you walk
__Enlarged heart
__Dizziness
__Swollen legs

Check off any heart problems:

__Heart attack
__High blood pressure
__Diabetes
__High cholesterol
__Heart failure
__Stroke
__Bypass surgery
__Valve surgery
__Stents
__Kidney problems
__Lung disease

Are you being treated now or have you been treated for any medical problems? Please list them

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Have you ever had any operations? Hospitalization? Injuries? (Hospital name, year, and reason)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Allergies: __NO __YES (if yes answer below)

___Penicillin ___Sulfa ___Aspirin ___Sedatives ____Narcotics ____X-Ray Contrast ___Other_____

Please tell us about your medications (names, dose or strength, how many times a day).
Including over-the-counter

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____
13. _____ 14. _____

HEALTH HABITS:

Do you currently smoke? __NO __YES Were you a former smoker? __NO __YES
How many packs per day? ____ How many years? _____
How much alcohol do you drink? _____
Do you use any recreational drugs? __NO __YES List: _____
Do you use caffeine/coffee? __NO __YES
Do you exercise regularly? __NO __YES

SOCIAL HISTORY

Marital status: __S __M __W __D
With whom do you live? _____
Occupation: _____
Leisure Actives: _____
Recent travel history _____

FAMLIY HISTORY

Check if any close family members (parents, brothers, sisters, or children) have:
__**Heart attack** (__Father, __Mother, __Grandparent, __Sibling)
__**Bypass surgery** (__Father, __Mother, __Grandparent, __Sibling)
__**High blood pressure** (__Father, __Mother, __Grandparent, __Sibling)
__**Diabetes** (__Father, __Mother, __Grandparent, __Sibling)
__**High cholesterol** (__Father, __Mother, __Grandparent, __Sibling)
__**Heart failure** (__Father, __Mother, __Grandparent, __Sibling)
__**Stroke** (__Father, __Mother, __Grandparent, __Sibling)
__**Sudden death** (__Father, __Mother, __Grandparent, __Sibling)
__**Cancer** (What type? _____)
(__Father, __Mother, __Grandparent, __Sibling)

If your parents are deceased, please indicate the cause of death and age of death:

Father: _____ Age: _____
Mother: _____ Age: _____

Do you have any other special concerns or additional information we should be aware?

_____
_____
_____

REVIEW OF SYPTOMS (Please circle all that apply)

Cardiac:	Chest Pain	Palpitations	Unusual Sweating	Stroke	
Vascular:	Leg Pain	Swelling	Phlebitis	Calf Pain	
Constitutional:	Weight Gain	Weight Loss	Fever		
HEENT:	Vision Changes	Hearing Loss			
Respiratory:	Snoring	Coughing Up Blood	Shortness of Breath	Asthma	TB
	Inhalers	Valley Fever	Pneumonia/Pleurisy		
Gastrointestinal:	Nausea	Reflux	Bloody Stools	Diarrhea	Constipation
	Gall Bladder Trouble	Frequent Abdominal Pain	Change in Bowel Habits	Indigestion or Heartburn	Peptic Ulcers
Genitourinary:	Blood in Urine	Night-time Urination >2	Leaking Urine	Painful Urination	Kidney Stones
	Urinary Tract Infection				
Psychiatric:	Depression	Hallucinations	Anxiety	OCD	
Reproductive (Men):	Venereal Disease	Erectile Dysfunction			
Reproductive (Women):	Venereal Disease	Infertility	Oral Contraceptives	Irregular Menstruation	Painful Menstruation
	Irregular Pap Smear	Menopause	Pregnancies Total:	Miscarriages Total:	Terminations Total:
Endocrine:	Goiter	Tremor	Enlarged Glands	Thyroid Disease	
Dermatological:	Rash	Skin Sores	Hives		
Muscoskeletal:	Joint Pain	Muscle Aches	Scoliosis	Broken Bones	Arthritis