Central Florida Cardiovascular Consultants, P.L.

Ratan K. Ahuja, M.D., F.A.C.C.
Syed Abid Mahmood, MD, FACC
David Joseph, MD, FACC
Balaji Shanmugam, MD

Please fill out all pages as completely as possible.

NAME _____ Date of Birth _____ Age_____

DATE _____ Referring Physician _____

CHIEF COMPLAINTS:

_____
_____
_____

PAST MEDICAL HISTORY (Have you had these?)

CARDIAC:

Hypertension	Yes _____	No _____
Heart attack	Yes _____	No _____
Congestive heart failure	Yes _____	No _____
Heart catheterization	Yes _____	No _____
Heart bypass surgery	Yes _____	No _____
Stress test	Yes _____	No _____
Echocardiogram	Yes _____	No _____

ENDOCRINE

Diabetes	Yes _____	No _____
High cholesterol	Yes _____	No _____
Hypothyroidism	Yes _____	No _____
Hyperthyroidism	Yes _____	No _____

NEUROLOGICAL

Stroke	Yes _____	No _____
Epilepsy	Yes _____	No _____

VASCULAR

Peripheral Vascular Disease	Yes _____	No _____
Carotid Artery Disease	Yes _____	No _____

RESPIRATORY:

Bronchial Asthma	Yes _____	No _____
Pneumonia	Yes _____	No _____
Emphysema	Yes _____	No _____
Lung cancer	Yes _____	No _____

GASTROINTESTINAL

Peptic Ulcer Disease	Yes _____	No _____
Hepatitis	Yes _____	No _____
Irritable Bowel Syndrome	Yes _____	No _____
Ulcerative Colitis	Yes _____	No _____
Crohn's Disease		

UROLOGICAL

Kidney Stones	Yes _____	No _____
Chronic Kidney Disease	Yes _____	No _____
Benign Prostatic Hypertrophy	Yes _____	No _____

OTHERS:

Arthritis	Yes _____	No _____
Bleeding disorders	Yes _____	No _____
Cancer	Yes _____	No _____

LIST ANY OTHER DISEASES: _____
_____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

_____
_____
_____

ALLERGIES (To the following medications, please check)

Penicillin _____ Sulfa _____ Aspirin _____ Shellfish _____ IV Dye _____
Other medications: Please name _____

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

FAMILY MEDICAL HISTORY (Has any blood relative ever had?)

YES	NO		WHO	YES	NO		WHO
____	____	Diabetes	_____ ;	____	____	Cancer	_____
____	____	High Blood Pressure	_____ ;	____	____	Stroke	_____
____	____	Heart Disease	_____ ;	____	____	Abnormal Bleeding	_____

SOCIAL HISTORY

Female Patients: Are you pregnant or do you think you are pregnant? _____ Yes _____ No

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Are you currently using **tobacco**? Yes ____ No ____ # packs per day _____ for how many years? _____
How long after you wake up do you smoke your first cigarette?_____
How ready are you to quit? (check one) _____Ready to quit? _____Thinking about quitting? _____Not ready to quit?
Did you use tobacco in the past? Yes ____ No ____ # packs per day _____ for how many years? _____
Date you quit _____
Do you use **alcohol** regularly? Yes ____ No ____ how much per day _____ for how many years? _____
Do you **exercise** regularly? Yes ____ No ____ Are you on a regular diet? _____

REVIEW OF SYSTEMS

CARDIAC

Shortness of breath	Yes _____	No _____
Chest pain	Yes _____	No _____
Heart Palpitations	Yes _____	No _____
Dizziness, fainting	Yes _____	No _____
Ankle Swelling	Yes _____	No _____

ENDOCRINE

Excessive Thirst	Yes _____	No _____
Increased urination	Yes _____	No _____
Heat or cold intolerance	Yes _____	No _____
Rising to Void, more than once per night	Yes _____	No _____

NEUROLOGICAL

Severe Headaches	Yes _____	No _____
Confusion	Yes _____	No _____
Weakness in Arm/Leg	Yes _____	No _____
Transient Blindness	Yes _____	No _____

VASCULAR

Calf Pain on Ambulation	Yes _____	No _____
Numbness/Tingling in Feet	Yes _____	No _____

RESPIRATORY

Cough	Yes _____	No _____
Spitting of blood	Yes _____	No _____
Wheezing	Yes _____	No _____

GASTROINTESTINAL

Abdominal pain or heartburn	Yes _____	No _____
Nausea, vomiting	Yes _____	No _____
Diarrhea	Yes _____	No _____
Constipation	Yes _____	No _____
Blood in Stool	Yes _____	No _____

GENERAL REVIEW

Weight change	Yes _____	No_____
Extreme Fatigue	Yes _____	No _____
Fever	Yes _____	No _____
Joint pains	Yes _____	No _____
Excessive bruising	Yes _____	No _____
Impaired sight	Yes _____	No _____
Nose bleed	Yes _____	No _____
Anxiety	Yes _____	No _____