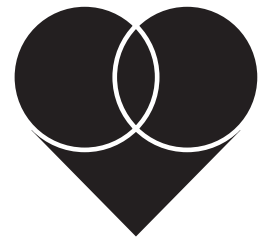


Heart Success Program

Saint Thomas Medical Group



4230 Harding Pike, Suite 900, Nashville, TN 37205
Phone: 615-964-5841 Fax: 615-250-4100

Patient Information

Name:	Date:	
Age:	DOB:	Sex at Birth: <input type="checkbox"/> M <input type="checkbox"/> F
Height:	Weight:	Race:
Doctor who sent you:	Office Phone No.	City (if not local):
Marital Status:	Children:	Occupation:
Education: <input type="checkbox"/> HS <input type="checkbox"/> College		
Reason for today's visit (list problems / concerns):		

Heart History / Risk Factors

	No	Yes	If yes, explain with the year & doctor / hospital
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	
Angioplasty / Stent / Balloon / Roto-Rooter	<input type="checkbox"/>	<input type="checkbox"/>	
Coronary (Heart) Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other Heart Surgery (Valve Replaced / Defect Repair)	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Rhythm Problem / Ablation / AFIB	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Failure / Weak Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Birth Defect	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Valve (Leaky or Tight)	<input type="checkbox"/>	<input type="checkbox"/>	
Pericarditis (Inflammation Around Heart)	<input type="checkbox"/>	<input type="checkbox"/>	

Past Heart Testing

	No	Yes	If yes, Date, Place, Doctor
Arteriogram (Heart Cath, Angiogram)	<input type="checkbox"/>	<input type="checkbox"/>	
Echocardiogram (Ultrasound Via Chest)	<input type="checkbox"/>	<input type="checkbox"/>	
TEE (Ultrasound Via Throat)	<input type="checkbox"/>	<input type="checkbox"/>	
Nuclear Stress Test (Cardiolite, Thallium)	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Test, Treadmill, Medicine Stress Test	<input type="checkbox"/>	<input type="checkbox"/>	
Wearable Heart Monitor	<input type="checkbox"/>	<input type="checkbox"/>	
EP Study (Catheter Test for Heart Rhythm)	<input type="checkbox"/>	<input type="checkbox"/>	

Past Heart Testing (Cont.)

	No	Yes	If yes, Date, Place, Doctor
MRI Scan of the Heart			
CT Scan of the Heart			
PET or Other Scan			
List any additional heart problems / tests not listed above:			

Heart Disease Risk Factors

	No	Yes	
High Cholesterol			
High Blood Pressure			
Diabetes			
Exercise Regularly			Times a Week
Ever Smoked, Used Tobacco, Vape			Times a Week
Quit?			When
Drink Alcohol, Beer or Wine?			Times a Week
Non Prescription Drugs? (Marijuana, Cocaine, Meth)			Times a Week
Fast Food More Than 2 Times Weekly?			
Pre-Eclampsia / Eclampsia			

Family Medical History

[illegible]

Other Medical Conditions

General	No	Yes		No	Yes		No	Yes
Fatigue			ENT			Dermatologic		
Fever			Hearing Loss			Rash		
Night Sweats			Ringing in Ears			Skin Sores		
Weight Gain			Dizziness			Musculoskeletal		
Weight Loss			Nosebleeds			Back Pain		
Heart			Hoarseness			Joint Pain		
Chest Pain			Gastrointestinal			Muscle Cramps / Aches		
Chest Pressure			Abdominal Pain			Hematologic		
Trouble Breathing / Night			Constipation			Easy Bleeding		
Palpitation			Diarrhea			Easy Bruising		
Fainting			Difficulty Swallowing			Excessive Bleeding		
Dizzy Spells			Vomiting			Blood Clots		
Leg Pain with Walking			Vomiting Blood			Immunological		
Swelling of Legs			Hemorrhoids			Asthma		
Blood Clots			Indigestion / Heartburn			Environmental Allergies		
Lungs			Blood in Stool			Food Allergies		
Cough			Nausea			Hay Fever		
Shortness of Breath			Reflux / Heartburn			Endocrine		
Coughing Up Blood			Genitourinary			Thyroid Enlargement		
Wheezing			Painful Urination			Unusually Thirsty		
Neurologic			Frequent Urination			Psychiatric		
Confusion			Blood in Urine			Anxiety		
Weakness			Difficulty Urinating			Depression		
Headache			Urinating at Night			Hallucinations		
Memory Loss			Reproductive			Increased Stress		
Paralysis			Birth Control Pills					
Seizures			Heavy Periods					
			Erectile Dysfunction					

List any other symptoms / conditions:

Medications

List all prescribed / over the counter medicines, supplements, vitamins, and herbs.
List the number of pills and number of times taken each day.

Name	Strength	Number of pills / times per day
Example: Lipitor	40 mg	One at bedtime

Allergies

List all medicines, X-ray dyes, foods or products that give you problems.
(Examples: Sulfa, Penicillin, Codeine, Tetanus Shot, IVP Dye, Eggs, Shellfish, Latex)

Substance	Problem

Surgical History

List	Date

Patient's Signature	Date
Name of person completing this form (if other than patient)	