Heart Success Program

Saint Thomas Medical Group

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Patient Information

Name:		Date:
Age:	DOB:	Sex at Birth: ☐ M ☐ F
Height:	Weight:	Race:
Doctor who sent you:	Office Phone No.	City (if not local):
Marital Status: Children:	Occupation:	Education: ☐ HS ☐ 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			
Angioplasty / Stent / Balloon / Roto-Rooter			
Coronary (Heart) Bypass Surgery			
Other Heart Surgery (Valve Replaced / Defect Repair)			
Pacemaker / Defibrillator			
Heart Rhythm Problem / Ablation / AFIB			
Heart Failure / Weak Heart			
Heart Murmur			
Rheumatic Fever			
Heart Birth Defect			
Heart Valve (Leaky or Tight)			
Pericarditis (Inflammation Around Heart)			

Past Heart Testing

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

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

Check all relatives that have these problems	Mother	Father	Sister	Brother	Grandparent
High Blood Pressure					
Stroke					
Diabetes					
High Cholesterol					
Heart Attack					
Heart Rhythm Problem / Pacemaker					
Heart Failure / Weak Heart / Enlarged Heart					
Inherited (Amyloid)					
Other:					

Other Medical Conditions

General	No	Yes	**ENT**	No	Yes	**Dermatologic**	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 Disfunction					

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)