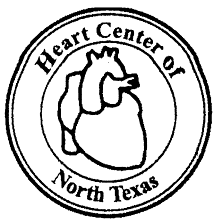

HEART CENTER OF NORTH TEXAS, P.A.

CARDIOLOGY

Dear ________________________________

Welcome to the Heart Center of North Texas. Your appointment has been scheduled for________________________at_________________________with Dr. Newman.

Your appointment will be at our Weatherford office located at 920 Hilltop Drive, behind the post office.

Please fill out the following paperwork and bring it with you to your appointment along with your drivers' license or picture ID and your insurance cards. Please do not mail back this paperwork.

If for any reason you are unable to keep this appointment please contact our office at 817-334-2800 and we will gladly reschedule your appointment to a more convenient time.

NOTE: If your insurance requires a referral, you are responsible for notifying your primary doctor so they can obtain one. If we do not receive the referral by your appointment time, you will be rescheduled.

Thank you,

Heart Center of North Texas

PLEASE BRING A LIST OF ALL MEDICATIONS WITH YOU TO YOUR APPOINTMENT

1017 12TH AVENUE
FORT WORTH, TEXAS, 76104
P: 817-334-2800 F: 817-820-0094

920 HILLTOP DRIVE
WEATHERFORD, TEXAS 76086
P: 817-613-9082 F: 817-613-8590

Diagnostic & Preventative Cardiovascular Medicine
Consultation Clinic
Stephen D. Newman, M.D., FACC, FAHA, FASNC

Welcome to the Heart Center of North Texas. We want your visit with us to be beneficial and informative. We ask that you take the time to answer the following questions so that we can gain a better understanding of your problems.

Name:________________________________ DOB:____/____/____ Today's date:____/____/______

Age:_______ M F

Your primary physician:___________________________

Your referring physician:.___________________________

Chief complaint (the reason for the doctor visit today)___________________________

Historical Information

Location (where is the pain/problem)___________________________

Onset (when did it first begin)___________________________

Severity (how severe is the pain/problem)___________________________

Timing (when does it occur) ___________________________

Quality (how does it feel) ___________________________

Duration (how long does it last)___________________________

Where were you when first noted ___________________________

What were you doing when first noted___________________________

What makes it better or worse ___________________________

Are there other associated symptoms ___________________________

Additional information regarding your pain or problem being evaluated today: ___________________________

____

____

Past Medical History:

Diabetes	Yes	No
High blood pressure	Yes	No
Cancer	Yes	No
Stroke/mini (TIA)	Yes	No
Lung disease	Yes	No
Arthritis/joint disease	Yes	No
Bleeding easily	Yes	No
Stomach/liver disease	Yes	No
Depression	Yes	No
High cholesterol	Yes	No
Kidney disease	Yes	No
Menopause	Yes	No
________________	Yes	No

Past Cardiovascular History:

Prior heart attack	Yes	No
Heart bypass	Yes	No
PTCA/angioplasty	Yes	No
Heart stent	Yes	No
Heart failure/weak heart	Yes	No
Heart valve disease	Yes	No
Rhythm disorder	Yes	No
Pacemaker/AICD	Yes	No
Prior cardiac arrest	Yes	No
Poor circulation in legs	Yes	No
Edema/vein disease	Yes	No
Echo, stress test, or cath	Yes	No
________________	Yes	No

Personal and Social History:

Marital status: []Single []Married []Separated []Divorced []Widowed

Use of alcohol: []Never []Quit . []Rarely []Moderately []Daily []Heavy

Use of tobacco: []Never []Quit: I quit in and smoked______packs per day x __.__ years.

[]Current smoker:__________packs per day x________years.

[]Chew: describe how much and how long ________________

Use of drugs: []Never []Type/frequency/IV___________________________

Stressors: []Job []Family []Spouse []Other___________________________

Physical activity: How much/often:___________________

Dietary habits: · Describe diet:__________ • __________________

Hours of sleep/day:__________________Do you wake up frequently? Yes No

Name:____DOB: _ /______________

____/ Page 2

Family Medical History:

Member	*Alive*	*Deceased*	*Age*	*Health problems or cause of death (ie heart attack, stroke, diabetes)*
Father	D	D		______________________________
Mother	D	D		______________________________

Tell me about diseases and age of death in siblings, children, or grandparents: ______________________

____

____

****Please note anyone who died young or suddenly with heart attack, cardiac arrest, or birth defects****

What surgeries or accidents have you had?____

____

What medications, supplements, or vitamins do you take? (or supply a current list)

____

____

____

____

____

Review of medical symptoms and problems:

Constitutional Symptoms:

Good general health	Yes	No
Recent weight change	Yes	No
Fever/chills	Yes	No
Feel tired all the time	Yes	No
Reduced tolerance	Yes	No

Cardiovascular Symptoms:

Heart trouble	Yes	No
Chest pain/angina	Yes	No
Wake up short of breath	Yes	No
Passing out	Yes	No
Heart racing/irregular	Yes	No
Hard to breathe walking	Yes	No
Feet swelling	Yes	No

Respiratory:

Chronic cough	Yes	No
Shortness of breath	Yes	No
Asthma/wheezing	Yes	No
Emphysema/COPD	Yes	No
Blood in sputum	Yes	No
Sleep apnea/snoring	Yes	No
Daytime sleepiness	Yes	No
Blue digits/nose/ears	Yes	No
Clot in lungs	Yes	No

Hematology/Oncology:

Cancer______________	Yes	No
Blood disease	Yes	No
Platelet disease	Yes	No
Clotting problems	Yes	No

Musculoskeletal:

Joint pain	Yes	No
Joint swelling	Yes	No
Muscle weakness	Yes	No
Back/neck pain	Yes	No
Difficulty walking	Yes	No

Psychiatric Symptoms:

Memory loss	Yes	No
Confusion	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Hallucinations	Yes	No
Nervousness	Yes	No

Gastrointestinal:

Loss of appetite	Yes	No
Change in bowels	Yes	No
Nausea	Yes	No
Abdominal pain	Yes	No
Reflux belching	Yes	No
Constipation ·	Yes	No
Hiatal hernia	Yes	No
Bloody stools	Yes	No
Dark/tarry stools	Yes	No

Functional Status:

Independent	Yes	No
Walk flight stairs	Yes	No
Play sports	Yes	No
Yard work	Yes	No
Can you walk a mile		No

Neurological:

Headaches	Yes	No
Lightheaded	Yes	No
Seizures	Yes	No
Numbness	Yes	No
Tremor/shaking	Yes	No

Endocrine:

Thyroid disease	Yes	No
Excessive thirst	Yes	No
Hormone problems	Yes	No
Heat intolerance	Yes	No
Cold intolerance	Yes	No
Diabetes	Yes	No
Steroid use	Yes	No

Genitourinary:

Frequent urination	Yes	No
Blood in urine	Yes	No
Urine infections	Yes	No
Difficulty starting	Yes	No
Difficulty stopping	Yes	No
Pblm with erection	Yes	No
Sexual difficulty	Yes	No
Sexual interest	Yes	No

Allergy/Immunology:

Reactions to medications food or xrays?	Yes	No

____

____

____