Houston Electrophysiology Associates ▪ 6624 Fannin, Suite 1910, Houston, Texas 77030 ▪ Phone (713) 791-9444 ▪ Fax (713) 791-9555

PATIENT'S NAME: ______________________________ **DATE:** ____ / ____ / ______ (mm / dd / yyyy)

D.O.B.: ____ / ____ / ______ (mm / dd / yyyy) **AGE:** ______ **REFERRING PHYSICIAN:** ______________________

PHONE #: (_____) ______ - _______ (area code, phone number) **SOCIAL SECURITY #:** ______- ____ - _______ **MARITAL STATUS:** M S D W

ADDRESS: ______________________________

CITY / STATE / ZIP: ______________________ **OCCUPATION:** ______________________

HISTORY:

1. Reason your doctor asked you to come:

   A. ☐ Chest pain.
   B. ☐ Abnormal EKG.
   C. ☐ Abnormal exercise test.
   D. ☐ Other: ______________________________

If primary reason for appointment is chest discomfort, please answer questions 2 through 7.

2. Please describe the chest pain or discomfort, where it radiates, what brings it on, and other symptoms associated with the discomfort. ______________________________

3. A. Is the discomfort made worse by exertion: Yes ☐ No ☐

   B. Is the discomfort made better by rest: Yes ☐ No ☐

   C. Does the pain occur more with rest than with exercise: Yes ☐ No ☐

4. A. Is the chest discomfort relieved by Nitroglycerin: Yes ☐ No ☐

   If yes, how long does it take to respond to Nitroglycerin: ___________ minutes.

5. Duration of typical episode of chest pain or discomfort: ______________________________

6. Frequency of episodes of chest pain or discomfort (how many per day or week, etc.) ______________________________

   A. First episode of chest discomfort: ______________________________

   B. Most recent episode of chest discomfort: ______________________________

7. History of myocardial infarction (heart attack)? Yes ☐ No ☐

   A. When: ____ / ____ / ______ (mm / dd / yyyy)

   B. Where: ______________ (City) ______________ (State) ______________ (Country)

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8. Symptoms other than chest pain or discomfort:

A.	Shortness of breath	Yes ☐	No ☐
B.	Fatigue	Yes ☐	No ☐
C.	Dizziness, lightheadedness or fainting spells	Yes ☐	No ☐
D.	Smothering at night	Yes ☐	No ☐
E.	Ankle or leg swelling	Yes ☐	No ☐
F.	Heart irregularity (skipping, racing, pounding)	Yes ☐	No ☐
G.	Exercise-induced pain in legs	Yes ☐	No ☐
H.	Severe frequent headaches	Yes ☐	No ☐
I.	Cough without having a cold	Yes ☐	No ☐

9. Do you have a history of stroke? Yes ☐ No ☐

Date: ____ / ____ / ______ (mm / dd / yyyy) How affected: ______________________

Treatment/Evaluation: ______________________

____

PAST MEDICAL HISTORY:

1. Allergies to medications: ______________________

Allergies to foods: ______________________

2. Childhood diseases:

A.	Rheumatic fever	Yes ☐	No ☐	F.	Chicken pox	Yes ☐	No ☐
B.	Scarlet fever	Yes ☐	No ☐	G.	Measles	Yes ☐	No ☐
C.	Heart murmur	Yes ☐	No ☐	H.	Other: ______________		
D.	Mumps	Yes ☐	No ☐				
E.	Whooping cough	Yes ☐	No ☐		______________		

3. Other illnesses:

A. Enlarged heart: Yes ☐ No ☐ -- If yes, when diagnosed: ____ / ____ / ______ (mm / dd / yyyy)

B. Hypertension Yes ☐ No ☐ -- If yes, when diagnosed: ____ / ____ / ______ (mm / dd / yyyy)

C. Diabetes Yes ☐ No ☐ -- If yes, when diagnosed: ____ / ____ / ______ (mm / dd / yyyy)

D. Abnormal lipids *(cholesterol/triglycerides)* Yes ☐ No ☐

E. Other:

(i)	Hiatal hernia	Yes ☐	No ☐	(vii)	Encephalitis	Yes ☐	No ☐
(ii)	Ulcers	Yes ☐	No ☐	(viii)	Gallbladder disease	Yes ☐	No ☐
(iii)	Kidney problems	Yes ☐	No ☐	(ix)	Colon disease	Yes ☐	No ☐
(iv)	Hepatitis	Yes ☐	No ☐	(x)	Lung disease *(pneumonia, emphysema bronchitis, tuberculosis)*	Yes ☐	No ☐
(v)	Phlebitis	Yes ☐	No ☐				
(vi)	Meningitis	Yes ☐	No ☐				

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mm dd yyyy

D.O.B.: ____ / ____ / ______ **AGE:** ______ **REFERRING PHYSICIAN:** ______________________
mm dd yyyy

4. List any surgeries or hospitalizations that you may have had:

Reason for hospitalization	Hospital/City, State	Dates	
		To	From

5. Have you had any heart surgery: Yes ☐ No ☐

When: ____ / ____ / ______
mm dd yyyy

Where: ______________ ______________ ______________
City State Country

Physician: ______________________

6. Previous diagnostic testing:

A. Exercise test: ______________________

B. Coronary angiography (catheterization): ______________________

C. Echocardiogram: ______________________

D. Electrocardiogram: ______________________

E. Nuclear scans: ______________________

SOCIAL HISTORY:

1. Birthplace: ______________ ______________ ______________
City State Country

2. Habits:

A. Smoking: Yes ☐ No ☐

If yes, how many packs per day: ____________ Number of years: ____________

If you do not presently smoke, have you quit in the past? Yes ☐ No ☐

When: ____ / ____ / ______
mm dd yyyy

B. Alcohol drinking: Never ☐ Rare ☐ Occasionally ☐ Heavy ☐

C. Coffee drinking: Yes ☐ No ☐

If yes, how many cups per day: ____________

D. Religious restrictions (blood produces, etc.): Yes ☐ No ☐

If yes, please indicate: ______________________

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FAMILY HEALTH:

Relation		Age / Death	Cause	Stroke, heart attack, history of diabetes, high blood pressure, etc.
Mother				
Father				
Brothers and Sisters	1			
	2			
	3			
	4			
	5			
Children	1			
	2			
	3			
	4			

OTHER PROBLEMS *NOT* NOTED ABOVE (Please list):

#	Symptom	Date of Onset mm / dd / yyyy	Testing	Treatment	Physician
1					
2					
3					
4					
5					