

# PATIENT CONSULTATION

## Heart Group of the Carolinas

Office: Concord \_\_\_\_\_ Albemarle \_\_\_\_\_

Room #: \_\_\_\_\_

Doctor 1 2 6 7 8 9 10 11 12 13 14

Patient Name: \_\_\_\_\_ M.R.#: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Referring Diagnosis: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Please help us learn more about you by completing the LEFT side of this form (front and back).

**DO NOT WRITE IN THE SHADED AREAS.**

## PATIENT

Why are you seeing our cardiologist?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Check any of the following that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Angina                             |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Irregular heartbeats, palpitations |
| <input type="checkbox"/> Fainting                | <input type="checkbox"/> Shortness of breath                |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Blue lips or fingernails           |
| <input type="checkbox"/> Nitroglycerin used      | <input type="checkbox"/> Heart murmur                       |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Abnormal rhythm (Arrhythmia)       |
| <input type="checkbox"/> Enlarged heart          | <input type="checkbox"/> Chest pains or pressure            |
| <input type="checkbox"/> Swollen legs            | <input type="checkbox"/> Heart failure                      |
| <input type="checkbox"/> Leg cramps when walking | <input type="checkbox"/> High cholesterol                   |

### Check any of the following that you have had:

- |  |   |
|--|---|
| <input type="checkbox"/> Stress test             | <input type="checkbox"/> Echocardiogram                 |
| <input type="checkbox"/> Coronary bypass surgery | <input type="checkbox"/> Pacemaker/defibrillator        |
| <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> Coronary angioplasty (Balloon) |
| <input type="checkbox"/> Valve surgery           | <input type="checkbox"/> Electrophysiology study        |
| <input type="checkbox"/> Coronary stent          | <input type="checkbox"/> Heart monitor                  |

Do you have diabetes?  Yes  No

Do you exercise (including walking)  Yes  No

## CLINICIAN

CC

### HPI

C/P  Yes  No Quality \_\_\_\_\_

Onset (rest/activity) \_\_\_\_\_

Region \_\_\_\_\_

Duration \_\_\_\_\_

Relieved (Rest / NTG) \_\_\_\_\_

Occurs \_\_\_\_\_

SOB (w/pain/rest/activity) \_\_\_\_\_

Nausea  Yes  No Diaphoresis  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PV Disease  Y  N

Y N Y N

- |   |   |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Uncontrolled HTN (> 2 meds) | <input type="checkbox"/> <input type="checkbox"/> Arm Pain                  |
| <input type="checkbox"/> <input type="checkbox"/> Claudication                | <input type="checkbox"/> <input type="checkbox"/> Previous vascular disease |
| <input type="checkbox"/> <input type="checkbox"/> Non-healing ulcer           | <input type="checkbox"/> <input type="checkbox"/> TIA                       |
| <input type="checkbox"/> <input type="checkbox"/> Leg Pain                    | <input type="checkbox"/> <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Rest <input type="checkbox"/> < 2 Blocks             |   |
| <input type="checkbox"/> > 2 Blocks   |   |

Please complete the left side of this form. **Do not write in shaded area.**

## PATIENT

List any illnesses for which you've been treated

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List any previous surgeries or hospitalization

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Marital status:  single  married  widowed  divorced

With whom do you live? \_\_\_\_\_

Occupation \_\_\_\_\_

Do you smoke?  Yes  No

Yr Started \_\_\_\_\_ Yr Quit \_\_\_\_\_

Do you drink alcohol?  Yes  No

If yes, how often? \_\_\_\_\_

Do you use recreational drugs?  Yes  No  
(including cocaine, marijuana, etc.)

Is there a history of heart problems in your family?  Yes  No

If so, who or what \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications?  Yes  No

If so, list names of medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list names/dosage of all medications you are taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CLINICIAN

P F S H

### Past Medical History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Past Surgical History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Social History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Family History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medicines

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please **check any boxes** which apply to you and **circle any symptoms** you have so that we may learn more about you.  
**(Do not write in shaded areas.)**

**PATIENT**

- Lack of energy; trouble sleeping; loss of appetite; weight changes; fevers
- Eye problems, such as double or blurred vision; glaucoma; cataracts
- Hearing problems, buzzing or ringing in ears
- Allergies or hay fever
- Sinus problems
- Breathing problems; wheezing; cough; coughing blood
- Shortness of breath; asthma
- Stomach problems; indigestion; change in bowel habits; gallstones; liver problems; ulcers; bloody stools; jaundice
- Urinary Problems; frequency; infections; stones; bladder  
 Men: Prostate problems; night-time urination  
 Women: Abnormal menstrual periods  
 Could you be pregnant?  Yes  No
- Joint Pains; swelling or redness; arthritis; back pain
- Muscle aches or tenderness; gout
- Skin problems; itching or rash
- Paralysis (even temporary); stroke; numbness; loss of balance
- Seizures; headaches; loss of memory
- Depression; nervousness; suicide attempts; crying
- Thyroid disorder; diabetes; excessive thirst or urination
- Bleeding; easy bruising; risk factors for HIV; anemia; cancer

**Thank you for helping us learn more about you!**

**Do Not Write Below This Line**

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**CLINICIAN**

**ROS**

- Constitutional**  Yes  No
- HEENT**  Yes  No
- Respiratory**  Yes  No
- Digestive**  Yes  No
- Urinary**  Yes  No
- Musculoskeletal**  Yes  No
- Dermatological**  Yes  No
- Neurological**  Yes  No
- Psychiatric**  Yes  No
- Endocrinology**  Yes  No
- Hematological**  Yes  No
- All others negative**  Yes  No

**Physical Exam:**

Weight \_\_\_\_\_ Height \_\_\_\_\_ Pulse \_\_\_\_\_ Temp \_\_\_\_\_  
 BP: Supine (RT) \_\_\_\_\_ (LT) \_\_\_\_\_ Sitting (RT) \_\_\_\_\_ (LT) \_\_\_\_\_  
 Standing (RT) \_\_\_\_\_ (LT) \_\_\_\_\_

N=Normal A=Abnormal D=Deferred

**Description of Abnormal Finding**

1. Eyes ___ PERLA ___ Lids ___ Arcus ___ Xanth ___ Fundi																
2. ENT ___ Pharynx ___ Nodes																
3. Oral ___ Oral Mucosa ___ Teeth/Gums/Palate																
4. Neck ___ Thyroid ___ ROM ___ Carotid ___ JVD																
5. Resp ___ Effort ___ Ausc																
6. Heart ___ Rate/Rhythm ___ PMI ___ S3/S4 ___ Sounds ___ S1/S2 ___ Thrills/Rubs																
7. Abdomen ___ Masses/Tenderness ___ Liver ___ Spleen ___ Ausc																
8. Musculoskeletal ___ Back-curvature ___ Gait ___ Exercise tolerance ___ Strength ___ Tone																
9. Extremities ___ Clubbing ___ Edema ___ Cyanosis  <table border="0" style="width: 100%;"> <tr> <td style="text-align: center;"><b>Pulses</b></td> <td style="text-align: center;"><u>Right</u></td> <td style="text-align: center;"><u>Left</u></td> </tr> <tr> <td>Brachial</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Femoral</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Popliteal</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Post Tibial</td> <td>_____</td> <td>_____</td> </tr> </table>	<b>Pulses</b>	<u>Right</u>	<u>Left</u>	Brachial	_____	_____	Femoral	_____	_____	Popliteal	_____	_____	Post Tibial	_____	_____	Arrival _____ Form Y ___ N ___ Exam Room _____ Ready for Dr. _____ Departure _____
<b>Pulses</b>	<u>Right</u>	<u>Left</u>														
Brachial	_____	_____														
Femoral	_____	_____														
Popliteal	_____	_____														
Post Tibial	_____	_____														
10. Skin ___ (describe scars, rashes, etc.)																
11. NeuroPsych ___ Oriented ___ Mood																

**Medical Decision Making**

**Impression (DX)** \_\_\_\_\_

**Plan**

- EKG  F/U \_\_\_\_\_
- Stress Echo (Dobutamine/exercise)
- Thallium (Dipyridamole/dual isotope/sestamibi)
- Holter/KOH  CXR  Echo
- Cath/Intervention \_\_\_\_\_
- B.M.P.  LFT  FLP  PT
- Other Labs \_\_\_\_\_
- Rehab referral  Other \_\_\_\_\_
- Med changes \_\_\_\_\_

**Data reviewed:**

- LAB (Date) \_\_\_\_\_
- PT  Thyroid
  - CHOL  B.M.P.
  - TG  Other \_\_\_\_\_
  - NI Study (Date) \_\_\_\_\_
  - Invasive (Date) \_\_\_\_\_
  - EKG (Date) \_\_\_\_\_
  - Other (List/Date) \_\_\_\_\_
  - Review of MR's \_\_\_\_\_

\_\_\_\_\_  
 Doctor's Signature

\_\_\_\_\_  
 Nurse's Signature