Johns Hopkins Bayview Medical Center
Women's Cardiovascular Health Center
Division of Cardiology

Today's Date: ___ /___ /____

First Name:_____ Middle Initial:_____ Last Name: _____

Date of Birth: ___ /___ /____ Gender: M F

Race: Caucasian African American Hispanic Asian Other:_____

Marital Status (circle one) Single Married Widowed Divorced

With whom do you live? _____

Phone Number: (___)_____

Occupation:_____
If retired or disabled enter your last occupation

Retired? No Yes : Date of retirement:_____
Disability ? No Yes : Date of disability:_____

Highest Level of Education:_____

Who is your primary care doctor: _____
Where is your primary care doctor located ? _____
Phone Number of primary care doctor: (___)_____

Are you allergic to any medications? (circle one) Yes No
If yes, list the medication(s) and reaction: _____
_____
_____

Do you smoke? No Yes How many years did you smoke? _____
If you quit, when did you stop?: _____ How many packs per day ? _____

Do you drink alcohol? No Yes If you quit when did you stop? _____

Family History

	Alive or Deceased	Age (age at death if deceased)	Cause of death (if deceased)
Mother			
Father			
Sister 1			
Sister 2			
Sister 3			
Brother 1			
Brother 2			
Brother 3			

Please continue to next page

Did your mother or any of your sisters have a heart attack, heart surgery
Or ballon/angioplasty before age 65 ? Yes No

Did your father or any of your brothers have a heart attack, heart surgery
Or ballon/angioplasty before age 55 ? Yes No

Did anybody in your family have a heart attack or die suddenly
at a young age(in their teens, 20's or 30's) Yes No

Do you have any children? No Yes If so, how many? _____
Do your children have any medical problems: No Yes If yes, please specify_____
During your pregnancies were you diagnosed : No Yes
with new high blood pressure/preeclampsia
or diabetes?

Have you Ever Been Treated for any of the following

History of poor Circulation	Yes No		Diabetes	Yes No		Stomach Problems or Ulcers	Yes No
gh Blood Pressure	Yes No		High Cholesterol	Yes No		Hepatitis	Yes No
Breathing problems like Asthma or Emphysema	Yes No		Angina or chest discomfort	Yes No		Have you ever had any operations	Yes No
Stroke	Yes No		Heart Attack	Yes No		Anemia or low blood count	Yes No
Heart Murmur	Yes No		Thyroid Problems	Yes No		Kidney Problems	Yes No
Anxiety	Yes No		Rheumatoid Disorder	Yes No			Yes No

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

_____

_____

_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS:

Date	Reason

Please continue to next page

DO YOU HAVE ANY OF THESE SYMPTONS? (circle answer)

Weight Loss	Yes No	Passing out episodes	Yes No	Headaches	Yes No
Palpitations or rapid beating heart	Yes No	Changes in bowl habits	Yes No	Seizures	Yes No
Shortness of breathe at rest	Yes No	Nausae/vomiting/ diarrhea	Yes No	Temporary blindness in eye	Yes No
Unusual shortness of breathe on exertion	Yes No	Vomiting blood or blood in your bowel movements	Yes No	Numbness in arm or leg	Yes No
Difficuly breathing At night	Yes No	Painful urination	Yes No	Leg pain/fatigue with walking	Yes No
Chronic cough	Yes No	Excessive bleeding or Easy bruising	Yes No	Abdominal pain	Yes No
Chest pain or pressure at rest	Yes No	Chest pain or pressure exertion	Yes No	Anxiety	Yes No

<u>Please answer the following two questions about your recent mood</u>.

	Yes	No
1. In the past month have you often been bothered by feeling down, depressed, or hopeless?	☐	☐
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐