WEST MICHIGAN CARDIOLOGY

Grand Rapids
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Greenville
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Lakeview
420 S. Lincoln Avenue, Lakeview, MI 48850
616.754.9146 Toll Free 888.259.8043

Patient Information Profile

Date _____ Name _____ Date of Birth _____

Primary Care Physician _____

Please x the box if you have been feeling any of the following:

- ❑ Fevers or Chills
- ❑ Fatigue
- ❑ Weight Loss/Gain
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Chest Pain
- ❑ Irregular Heartbeats
- ❑ Heartburn
- ❑ Abdominal Pain
- ❑ Change in Stools
- ❑ Difficulty Urinating
- ❑ Dizziness
- ❑ Muscle Aches/Weakness
- ❑ Leg Swelling
- ❑ Numbness/Tingling
- ❑ Passing Out
- ❑ Leg/Buttocks/Hip Pain with walking
- ❑ Depression/Anxiety

Please x the box if you have any of the following:

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ High Cholesterol
- ❑ Coronary Artery Disease
- ❑ Previous Heart Attack
- ❑ Congestive Heart Failure
- ❑ Vascular Disease
- ❑ Stroke
- ❑ Rheumatic Fever
- ❑ Sleep Apnea
- ❑ Atrial Fibrillation
- ❑ Emphysema
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Acid Reflux
- ❑ Stomach Ulcers
- ❑ Liver Disease (Hepatitis)
- ❑ Bleeding Disorders
- ❑ Blood Clots
- ❑ Cancer
- ❑ Seizures
- ❑ HIV/AIDS
- ❑ Others Not Listed

❑ None

MEDICATIONS *(Including Over-The-Counter Medications)*

Name	Dose	Frequency	Name	Dose	Frequency

Are you allergic to any medication? ❑ Yes ❑ No

If yes, please list them: _____

Are you allergic to Shellfish? ❑ Yes ❑ No Are you allergic to Iodine? ❑ Yes ❑ No

Are you allergic to Latex? ❑ Yes ❑ No

Family History (*Check/Answer All That Apply*):

Living?	Yes	No	(Describe Heart I Circulatory Problems):
Father	❑	❑	_____
Mother	❑	❑	_____
Brother(s)	❑	❑	_____
Sister(s)	❑	❑	_____
Children	❑	❑	_____

List any past surgeries (including heart bypass, valve surgeries, pacemaker, stent placement or angioplasty)

_____

_____

_____

_____

Have you ever had any of the following heart testing? If so, when and location?

❑ Echocardiogram _____

❑ Stress Test _____

❑ Heart Catheterization _____

Are you: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Occupation: _____

Are you retired? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No

If yes, how often? _____

Do you currently smoke/or have a history of smoking?

❑ No ❑ Active ❑ Quit

Packs/Day _____ Years _____ Quit Smoking _____

❑ Cigarettes ❑ Pipe ❑ Cigars ❑ Chew

Do you drink alcohol? ❑ Yes ❑ No

How often? ❑ Rarely ❑ Occasionally ❑ Daily

❑ Beer ❑ Wine ❑ Mixed Drinks/Liquor

Do you do any recreational drugs? (example: marijuana, cocaine, etc.)

❑ Yes ❑ No ❑ Quit

If yes, what and how often: _____

_____