

METRO NORTH CARDIOVASCULAR & ASSOCIATES, P.A

Patient Symptom Check List

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Please check any of the following new or ongoing symptoms that apply to you:

1.) Are you or have you been experiencing Chest Pain? Yes ___ or No ___ Patient denies chest pain
(Patient Initial)

Type of Pain:

Achy/Gnawing ___ Burning ___ Tightness ___ Sharp ___ Squeezing ___ Heaviness ___ Pressure ___ Indigestion-Like ___ Tearing or Ripping ___

Onset/Timing (When did it begin): Suddenly ___ Gradually ___ Intermittently (Comes and goes) ___

How long has it been happening: ___ Day(s) ago. Today ___ Yesterday ___ ___ Week(s) ago ___ Month(s) ago
Greater than 6 months ___ Greater than one year ___

Location: Center of chest ___ Left side of chest ___ Right side of chest ___ Neck/Jaw ___ Shoots across chest ___
Mid-Epigastric ___ Infrascapular (Between Shoulder Blades) ___ Arm Pain ___ Which Arm _____

Quality/Course: Continuous ___ Intermittent ___ Acute ___ Chronic ___

Intensity/Severity: Scale of symptoms from 1-10 (1=Slight 10=Severe) 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___
10 ___ Mild ___ Moderate ___ Severe ___.

When do you feel the chest pain? While Sleeping ___ A rest ___ When Stressed ___ With exertion ___ Climbing stairs ___
With Palpitations ___ Other: _____.

Accompanied By: Fainting or Dizziness ___ Headache ___ Nausea/Vomiting ___ Rapid or irregular heartbeat ___
Shortness of breath ___ Unexplained fatigue ___ Sweating ___.

2.) Are you or have you been experiencing any Shortness of Breath? Yes ___ or No ___ Patient denies shortness of breath
(Patient Initial)

Triggered or worsened By: Mild to moderate exertion ___ Smoking ___ When stressed ___ Walking up stairs ___
While at rest ___ Walking ___ Chest pain ___ Palpitations ___

Accompanied By: Chest Pain, tightness or discomfort ___ Irregular or rapid heartbeat ___ Fainting or Dizziness ___
Fatigue or Weakness ___ Swelling of legs, ankles or feet ___ , If so, which? Right leg ___ Left leg ___ Sweating ___

Intensity/Severity: Mild ___ Moderate ___ Severe ___

Do you have a history of any of the following: Asthma__ COPD__ Emphysema__ Use of Supplemental Oxygen__ Atrial Fibrillation__ Cardiac Arrhythmia__ Sleep Apnea__ , If so do you use a CPAP Yes__ No__ . Autopap Yes__ No__ . Mouth Guard Yes__ No__ . Pacemaker__

3.) Are you or have you been experiencing any Palpitations?: Yes__ or No__ . Patient denies feeling any palpitations__ (Patient Initial)

My heart rate feels: Faster than normal__ Slower than normal__ Irregular/Unsteady__ Flip/Flop__ Flutters__ Spasms__ When does it occur : While at rest__ When stressed__ Laying down__ Sleeping__ With or after exertion__ Other: _____.

Location: Right side of chest__ . Center of chest__ . Left side of chest__ . Throat__ . Intensity/Severity: Mild__ Moderate__ Severe__ . How long has it been happening: __Day(s) ago. Today__ Yesterday__ __Week(s) ago __Month(s) ago Greater than 6 months__ Greater than one year__

Intensity/Severity: Mild__ Moderate__ Severe__

Accompanied By: Chest Pain or discomfort__ Shortness of Breath__ Dizziness or lightheadedness__

Do you use any of the following: Caffeine (Tea, Sodas, Coffee or Chocolates)__ , if so, how many cups per day?____ Cigarettes__ , if so how many per day?____ . Recreational drugs__ , If so, which? _____ Steroids__ Inhalers__ Nebulizer Treatments__

4.) Are you or have you been experiencing any Dizziness?: Yes__ or No__ . Patient denies feeling any dizziness__ (Patient Initial)

Symptoms Feel like: A Spinning sensation__ Unsteady__ Faint__ Lightheaded__ Other:_____.

Accompanied By: Headache__ Blurred or double vision__ Chest Pain or discomfort__ Facial Numbness__ Nausea__ Irregular Heart beat__ Ringing in ear__ Trouble concentrating__ Memory Loss__

Intensity/Severity: Mild__ Moderate__ Severe__

How long has it been happening?: __Day(s) ago. Today__ Yesterday__ __Week(s) ago __Month(s) ago Greater than 6 months__ Greater than one year__ Triggered or worsened by: A change in body position__ Turning of the head__ Other_____

5.) Are you or have you been experiencing any fatigue?: Yes__ or No__ . Patient denies feeling any fatigue__ (Patient Initial)

Intensity/Severity: Mild__ Moderate__ Severe__ Do you sleep well: Y__N__ Average number of hours spent sleeping per night: _____.

Does your fatigue keep you from performing any daily activities? Y__N__ Explain:

6.) Are you or have you been experiencing any edema(swelling)? Yes__ or No__ . Patient denies feeling any edema__ (Patient Initial)

Please specify location (be specific): _____.

How long has it been happening?: ___ Day(s) ago. Today ___ Yesterday ___ Week(s) ago ___ Month(s) ago
Greater than 6 months ___ Greater than one year ___ Intensity/Severity: Mild ___ Moderate ___ Severe ___

Accompanied by: Shortness of breath ___ Right leg pain ___ Left leg pain ___

Other: _____.

7.) Since your previous visit in our office, have you had any of the following:

Knee Surgeries: Y ___ N ___ If so, Right ___ or Left ___? When? _____.

Back Surgeries: Y ___ N ___ If so, What part of your back? _____ When? _____.

Hip Surgeries: Y ___ N ___ If so, Right ___ or Left ___? When? _____.

Do you have trouble with any of the following activities?

Walking ___ Explain: _____ Bathing ___ Explain: _____

Dressing ___ Explain: _____ Housework ___ Explain: _____

Standing for long periods ___ Explain: _____ Walking up stairs ___ Explain: _____

Driving ___ Explain: _____

Is there any reason you would not be able to walk on a treadmill, if needed: Y ___ N ___ If yes, please explain the reason: _____

8.) Do you smoke, dip or vape? Yes ___ or No ___. If yes, what do you smoke? _____ How many packs or cans do you use daily? _____.

Former smoker: How long ago did you quit smoking? _____

Do you consume alcohol? Yes ___ or No ___. If yes, how many drinks do you consume per day? _____.

Do you or have you ever used illicit drugs? Yes ___ or No ___.
If yes, what drugs have you used? _____ When is the last time you used? _____.

9.) Family History: Is your Mother living or deceased? _____, if deceased, age upon death ____.

Is your Father living or deceased? _____, if deceased, age upon death ____.

Is there any family history of cardiovascular disease (Diabetes, High blood pressure, high cholesterol, Strokes, Heart attacks, Cardiac arrhythmias)? Yes ___ or No ___. If yes please explain: _____

10.) Are you currently or have you been experiencing any other symptoms that you would like to discuss with Dr. Garoutte? Yes ___ or No ___. If yes, please specify: _____