Pati ' #__________

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS:

Chest Pains: Y____N____ **If Yes, location:** Right Side______ Center______ Left Side _____

Type of Pain: Squeezing_____ Tightness_____ Burning_____ Sharp_____ Indigestion-Like____

Other ____

Duration of Pain: **Intermittent:** ______ **Constant:** _______ **Does it Radiate:** Y___N___

Where does it radiate to ____

Short of Breath: Yes_____ No______ When At Rest______ With Exertion_________

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Fatigue______ Edema _______ Palpitations _______ Dizziness _______ Fainting _______

Sleep Apnea____ Insomnia _____ Depression _____ Anxiety _____ Sinus Congestion ______

Ear Pain ______ Back Pain ______ Leg Pain ______ Jaw Pain _______ Throat Pain _______

Abdominal Pain: Yes_____ No _____ **If Yes:** Sharp _____ Dull ______ After Meals _______

Generalized Pain _____ Nausea or Vomiting ______ Diarrhea ______ Constipation ________

Headache: Y____N___ Frontal____ Occipital____ Sharp____ Throbbing____ Generalized_____

Cough: Y____N____ Productive____ Dry____ Sputum____ Yellow____ Green____ Clear____

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Cardiac Risk Factors: Smoking _____ High Blood Pressure _____ Diabetes Mellitus ______

High Cholesterol _____ Family History of Coronary Artery Disease ______

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Habits: Tobacco ___ Number of packs a day____ Alcohol___ Daily consumption __________

Illicit Drug Use ____ Drugs Used ____

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Do you have problems with: Walking _____ Bathing _____ Dressing_____ Shopping _____

Housework_____ Paying Bills_____ Memory _____ Concentrating_____ Feeling Unhappy_____

Transportation _____ Taking medication_____ Fixing Meals _____