Cardiology of San Antonio, P.A.

PATIENT UPDATE

Name: ________________________________ Date: _________________

D.O. B. _________________

1.Have you had any new illnesses/procedures since we have seen you last?

____

____

If so, were you Hospitalized? Yes No

Where?__________________________

When?_________________________

2. Do You smoke? _______ Did You smoke before? _________

How long?________

3. Do you have or have your ever been diagnosed with ANY of the following?

AIDS/HIV	Yes	No	High Cholesterol	Yes	No
Anemia	Yes	No	Irregular Heart Beat	Yes	No
Aneurysms	Yes	No	kidney Problems	Yes	No
Angina/Chest Pain	Yes	No	Palpitations	Yes	No
Artificial Heart Valve	Yes	No	Passing Out	Yes	No
Asthma	Yes	No	Peripheral Artery Disease	Yes	No
Bleeding Disorder	Yes	No	Psychiatric Problems	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Shortness of Breath	Yes	No
Emphysema	Yes	No	Sleep Apnea	Yes	No
Heart Attack	Yes	No	Smoker	Yes	No
Heart Disease	Yes	No	Stomach Ulcer	Yes	No
Heart Failure	Yes	No	Stroke/TIA	Yes	No
Hemophilia	Yes	No	Thyroid Disease	Yes	No
Hepatitis	Yes	No	Ulcers	Yes	No
High Blood Pressure	Yes	No			

4. Have you had any obstructions of arteries of the heart? Yes No
5. Have you had any surgeries, angioplasties or *stents* to any arteries of the Heart? Yes No
6. When you walk or do exercise, do you have any pain, or cramps or Pain in your arms, legs, muscles? Yes No

If you answered Yes, do you feel relief when you stop walking or stop exercise?
Yes No

7. Have you had any painful ulcers in the legs or feet that do not heal?
Yes No