



Date \_\_\_\_\_

Print Name \_\_\_\_\_

Allergies \_\_\_\_\_

1. Age \_\_\_\_\_
2. Sex ( ) Male ( ) Female
3. Weight in Pounds \_\_\_\_\_
4. Height \_\_\_\_\_
5. DOB \_\_\_\_\_
6. Coffee, tea, or chocolate this morning? \_\_\_\_\_
7. When was the last time you ate? \_\_\_\_\_

**Symptoms**

8. Chest pain?..... ( ) Yes ( ) No  
How long? \_\_\_\_\_  
Does the pain involve arm or neck? ..... ( ) Yes ( ) No  
Last time you had chest pain? \_\_\_\_\_
9. Shortness of breath?..... ( ) Yes ( ) No
10. Nausea/Vomiting? ..... ( ) Yes ( ) No

**Medical History**

11. Heart attack in the past?..... ( ) Yes ( ) No
12. Heart Surgery? ..... ( ) Yes ( ) No
13. Heart Catheterization? ..... ( ) Yes ( ) No  
Angioplasty? ..... ( ) Yes ( ) No
14. High blood pressure? ..... ( ) Yes ( ) No
15. Diabetes?..... ( ) Yes ( ) No
16. High cholesterol? ..... ( ) Yes ( ) No
17. Smoke? ..... ( ) Yes ( ) No
18. Asthma? ..... ( ) Yes ( ) No
19. Emphysema?..... ( ) Yes ( ) No
20. Family history of heart disease? ..... ( ) Yes ( ) No
21. Previous stress test? ..... ( ) Yes ( ) No  
When? \_\_\_\_\_  
Can you walk fast for 5 minutes or more?..... ( ) Yes ( ) No
22. Do you have glaucoma?..... ( ) Yes ( ) No
23. List the medication(s) you are taking and include the dose(s).  
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