ONTARIO CARDIOVASCULAR ASSOCIATES

PATIENT INFORMATION FORM

Please complete BOTH pages. Check Yes/No where applicable and write clearly.

PATIENT DETAILS

Last name: _____

First name: _____

Date of birth: _____

Health card #: _____

Phone: _____

Family doctor: _____

Pharmacy: _____

Reason for visit:

_____

_____

HEART DISEASE RISK FACTORS

	Yes	No
Ever smoked?	☐	☐
Currently smoking?	☐	☐
High blood pressure?	☐	☐
High cholesterol?	☐	☐
Diabetes?	☐	☐
Sleep apnea / CPAP?	☐	☐
Peripheral vascular disease?	☐	☐
Coronary artery disease / stent?	☐	☐

If stopped smoking, when?

_____

PREVIOUS HEART CONDITIONS

	Yes	No
Chest pain investigation?	☐	☐
Heart attack?	☐	☐
Pericarditis?	☐	☐
Heart failure?	☐	☐
Heart valve disease?	☐	☐
Atrial fibrillation / flutter?	☐	☐
Other heart rhythm problem?	☐	☐
Congenital heart condition?	☐	☐

Dates / details:

_____

PREVIOUS CARDIAC TESTS

	Yes	No
Holter / event monitor	☐	☐
Exercise stress test	☐	☐
Nuclear stress test	☐	☐
Echocardiogram	☐	☐
Coronary angiogram	☐	☐
Angioplasty / stent	☐	☐
Coronary bypass surgery	☐	☐
Pacemaker / defibrillator	☐	☐
Heart valve surgery	☐	☐
CT coronary angiography	☐	☐

Where / when (if known):

_____

PAST MEDICAL CONDITIONS

	Yes	No
Acid reflux / heartburn	☐	☐
Stomach ulcer / GI bleeding	☐	☐
Blood clots in legs / lungs	☐	☐
Aortic aneurysm	☐	☐
COPD / emphysema	☐	☐
Asthma	☐	☐
Kidney disease	☐	☐
Anxiety / depression	☐	☐
Stroke / TIA	☐	☐
Thyroid disorder	☐	☐
Varicose veins	☐	☐

OTHER CONDITIONS / SURGERIES

List other medical conditions, hospital stays and surgeries:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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MEDICATIONS & DOSES

Include prescriptions, aspirin, non-prescription and supplements.

DRUG ALLERGIES

[ ] No known medication allergies

Medication / reaction:

FAMILY HEART HISTORY

List relative, cardiac condition and age at diagnosis (if known):

CURRENT SYMPTOMS

	Yes	No
Chest pain / tightness?	☐	☐
Shortness of breath?	☐	☐
Breathless when lying flat?	☐	☐
Wake gasping for air?	☐	☐
Palpitations / racing heart?	☐	☐
Dizziness / lightheadedness?	☐	☐
Fainting / passing out?	☐	☐
Swelling of feet / legs?	☐	☐
Pain in legs with walking?	☐	☐
Cough?	☐	☐
Wheezing?	☐	☐
Unusual fatigue?	☐	☐
Recent weight change?	☐	☐

SOCIAL HISTORY

Occupation:

Alcoholic drinks per week:

Caffeinated drinks per day:

Recreational drugs / smoking:

IF YOU HAVE CHEST PAIN

When did it start?

Where is the pain located?

Does it occur at rest or with activity?

What does it feel like?

How long does each episode last?

What makes it worse?

What makes it better?

Any associated symptoms?

Please bring your medication list and any available cardiac test reports.