



**Loudoun  
Cardiovascular  
Specialists, PLLC**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's date: \_\_\_\_\_

Primary care doctor: \_\_\_\_\_ Other doctors: \_\_\_\_\_

What is your main reason (symptoms) for seeing a cardiologist? \_\_\_\_\_

List any allergies to medications *or* check box if no known allergies  : \_\_\_\_\_

\_\_\_\_\_ Allergy to iodine/contrast dye? \_\_\_\_\_

**Family History:**

	Which family member(s)?	Mother/Father's side	Age of occurrence?	Cause of death?
Heart Attack	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____
Other	_____	_____	_____	_____

Have you had any previous heart problems and how were they treated (including angioplasty or heart surgery)?

\_\_\_\_\_

\_\_\_\_\_

Previous tests/when: Stress test \_\_\_\_\_ ECG tracing \_\_\_\_\_ Echocardiogram (heart sonogram) \_\_\_\_\_  
 Holter monitor \_\_\_\_\_ Cholesterol test \_\_\_\_\_ Cardiac Catheterization \_\_\_\_\_

Have you had any of the following:

High blood pressure \_\_\_\_\_ If yes, how long? \_\_\_\_\_ Years treated \_\_\_\_\_  
 Diabetes \_\_\_\_\_ If yes, how long? \_\_\_\_\_ Years treated \_\_\_\_\_  
 High cholesterol \_\_\_\_\_ If yes, how long? \_\_\_\_\_ Years treated \_\_\_\_\_

	Yes/No	When		Yes/No	When
Heart attack	___/___	_____	Rheumatic fever	___/___	_____
Angina	___/___	_____	Heart valve infection	___/___	_____
Sleep Apnea	___/___	_____	Blood clots	___/___	_____
Asthma/Emphysema	___/___	_____	Mini-stroke or stroke	___/___	_____
Congestive heart failure	___/___	_____	Stomach ulcers	___/___	_____
Heart murmur	___/___	_____	Gastric reflux	___/___	_____
Mitral valve prolapse	___/___	_____	Kidney failure	___/___	_____
Fainting	___/___	_____	Liver failure	___/___	_____
Hyper/Hypothyroidism	___/___	_____	Hepatitis or HIV	___/___	_____

