Entira℠ FAMILY CLINICS
Where generations thrive

Cardiac Procedures
Patient Information Sheet

Patient Name:_____ **Appt Date:**_____

Which test are you having today? Echocardiogram

Date of Birth: _____ Age: _____ Male / Female *If female: Are you pregnant or breastfeeding° Yes / No*

Height: _____ Weight: _____ Phone Number: _____

Physician who ordered the test: _____ Clinic: _____

Reason for today's test: _____

Are you currently having symptoms: Yes / No
If yes, please describe:
_____

Yes / No	Do you have asthma?
Yes / No	If yes, do you use inhalers?
Yes / No	Current smoker
Yes / No	Previous smoker (quit more than 6 months ago)
Yes / No	Family history of coronary artery disease (angioplasty/stent, heart attack, bypass)
Yes / No	History of high cholesterol
Yes / No	Diabetic on insulin
Yes / No	Diabetic on oral agents for blood sugar
Yes / No	History of high blood pressure
Yes / No	Peripheral vascular disease
Yes / No	Previous heart attack Date: —_____
Yes / No	Previous coronary angioplasty /stent Date: _____
Yes / No	Previous coronary bypass surgery Date: _____
Yes / No	Heart valve surgery Which valve: _____ Date: _____
Yes I No	Pacemaker
Yes / No	Heart defibrillator

Office Use Only: **Please attach current / updated demographics sheet and most current insurance card to this form)**