610 Hawthorne Ave SE, Ste 110
Salem, OR 97301
Ph: 503-814-4440

MR: _____

Oregon Heart Center P.C.
Cardiac & Arrhythmia Services

NEW PATIENT HISTORY

PHYSICIAN: Fedor - Ghalili - Hughes - Iyengar - Kamineni
Krishnamurthy - Saha - Thompson

CLINIC SITE: Salem Dallas Grand Ronde Stayton

DATE: _____ REFERRING MD: _____

PATIENT: _____ REASON FOR YOUR VISIT: _____

DOB: _____/_____/_____ Age: _____ Sex: M F _____

MEDICATION ALLERGIES: _____ _____

_____ _____

PHARMACY: _____ DATE OF SYMPTOM(S) ONSET: _____

❑ I am already enrolled in Patient Portal.
❑ Please enroll me in Patient Portal!
My email address is:

_____

SELECT YES IF YOU HAVE EVER HAD

CARDIAC PROCEDURAL HISTORY

1) Heart Attack? . . . . . YES NO
   If yes, when? _____
2) Coronary Angiogram or balloon / stent procedure? . . . . . YES NO
   If yes, when? _____
3) Heart Surgery? . . . . . YES NO
   If yes, type: _____ when: _____
4) Echocardiogram? *(ultrasound of heart)* . . . YES NO

VASCULAR PROCEDURAL HISTORY

1) Pain in calves/thighs/buttocks when walking? . . . YES NO
   How far do you walk prior to pain? _____
2) Any sores on legs/feet? . . . . . YES NO
3) Previous surgery on arteries? *(legs, abdomen, neck)* . . . . . YES NO
4) Aneurysm? *(ballooning of artery)* . . . . . YES NO
5) Carotid Doppler? *(ultrasound of arteries of neck)* . . . . . YES NO
6) Arterial Doppler? *(leg circulation test)* . . . . YES NO

CARDIOVASCULAR RISK FACTOR SURVEY

1) Do you smoke/chew tobacco? YES NO
   Have you in the past? YES NO
   a. Packs/day? _____
   b. Years smoked? _____
   c. Year quit? _____
2) Are you diabetic? YES NO
   Type 1 or Type 2?
   How long? _____
3) Do you have a history of Peripheral Vascular Disease? YES NO
4) Do you have a history of high blood pressure? YES NO
   How long? _____
5) Do you have a history of high blood cholesterol? YES NO
6) Is there a family history of *Please list relationship: Parent, Siblings, Children ONLY*
   a. Heart Disease? _____ YES NO
   b. Diabetes? _____ YES NO
   c. Stroke? _____ YES NO
   d. Other? _____ YES NO

PAST MEDICAL HISTORY

Previous Surgeries and Chronic Conditions

	Type	*Date*	
1)	History of stroke?	YES	NO
2)	Any lung disease? *(COPD, Asthma)*	YES	NO
3)	Any GI issues? *(PUD, cirrhosis)*	YES	NO
4)	Any blood disorders? *(anemia)*	YES	NO
5)	Are you on Dialysis?	YES	NO
6)	History of cancer?	YES	NO
7)	_____		
8)	_____		
9)	_____		
10)	_____		
11)	_____		
12)	_____		
13)	_____		
14)	_____		

SOCIAL HISTORY / HABITS *(Circle selection)*

Marital Status: . . . . . Single Divorced Life Partner Married Widowed Unknown

Children: . . . . . YES NO

Caffeine Status: YES NO

Types *(select 2)* : Coffee Chocolate Tablets Soda Tea

Alcohol Status: Current Never Former

Year Quit: _____

Frequency: _____

Drug Use / Abuse Status: Current Never Former

Year Quit: _____

Type: _____

Frequency: _____

Route: _____

Primary Language: English or _____

Race: _____ or Decline

Ethnicity: _____ or Decline

REVIEW OF SYSTEMS

(Please check each box, if you have EVER HAD)

Cardiac	☐ Chest pain	☐ Diaphoresis *(sweating)*	☐ Orthopnea *(difficulty breathing while laying down)*
	☐ Palpitation	☐ Syncope *(fainting)*	
Vascular	☐ Claudication *(pain in calves / thighs / buttocks when walking)*	☐ Edema *(legs and ankles swell)*	
Constitutional	☐ Weight gain	☐ Weight loss	☐ Fever
HEENT	☐ Visual changes	☐ Hearing loss	
Respiratory	☐ Snoring	☐ Hemoptysis *(bloody sputum)*	☐ Dyspnea *(shortness of breath with activity)*
Gastrointestinal	☐ Nausea	☐ Reflux	☐ Bleeding *(rectal bleeding/ black or bloody stools)*
Genitourinary	☐ Hematuria *(blood in urine)*	☐ Nocturia *(nighttime urination)*	
Neurological	☐ Dizziness	☐ Memory loss	☐ Seizures
Psychiatric	☐ Depression		
Hematologic	☐ Acute anemia		
Reproductive	☐ Erectile dysfunction		
Endocrine	☐ Goiter *(thyroid gland growth)*		
Derm	☐ Rash	☐ Skin sores	
Musculoskeletal	☐ Joint pain	☐ Myalgia *(muscle pain)*	