Phoenix Heart PLLC

5859 W Talavi Blvd, Suite 100, Glendale, AZ 85306
Phone: 602-298-7777 Fax: 623-930-6060
www.phoenixheart.com

Patient information

For:
Date of Birth:
MRN:

Family History	**Have you had any of the following procedures?**	
[ ] Diabetes	**If so, when/where?**	
[ ] Heart Attack	[ ] Angioplasty/Stent	
[ ] High Blood Pressure	[ ] Heart/Blood Vessel Surgery	
[ ] High Cholesterol	[ ] Heart Catheterization	
[ ] Stroke	[ ] Heart Valve Replacement	
Personal History	[ ] Pacemaker/ICD	
Have you had your annual wellness check/follow up in the last 12 months?	[ ] Treadmill/Exercise Test	
[ ] Yes [ ] No	[ ] Cardiac Ultrasound	
	Social History	
[ ] AIDS/HIV	Smoking? [ ] Yes [ ] No	
[ ] Asthma	If yes, how many per day?	
[ ] Cancer	If you quit, when?	
[ ] Congestive Heart Failure	Alcoholic Beverages? [ ] Yes [ ] No	
[ ] Diabetes	If yes, how much per day?	
[ ] Emphysema/COPD (Lung Disease)	Exercise? [ ] Yes [ ] No	
[ ] Gout	If yes, how often and what type?	
[ ] Heart Attack If yes, when?	Caffeine? [ ] Yes [ ] No	
	If yes, how many per day?	
[ ] Heart Murmur	**Women Only**	
[ ] Hiatal Hernia/Reflux	Do you take oral contraceptives?	
[ ] High Blood Pressure If yes, how is it treated?	[ ] Yes	
	[ ] No	
[ ] High Cholesterol or Triglycerides If yes, how is it treated?	Are you pregnant?	
	[ ] Yes	
[ ] Irregular Heart Beats	[ ] No	
[ ] Kidney/Urinary Problems	Planning to become pregnant?	
[ ] Peripheral Vascular Disease	[ ] Yes	
[ ] Rheumatic Fever	[ ] No	
[ ] Seizures	Post-Menopausal?	
[ ] Stroke If yes, when?	[ ] Yes	
	[ ] No	
[ ] Thyroid disorder	Hysterectomy?	
[ ] Ulcers	[ ] Yes	
Experience any of the following?	[ ] No	
[ ] Bruise or Bleed Easily	If yes, when?	
[ ] Cough		
[ ] Chest Pain/Pressure/Discomfort	**Men Only**	

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[ ] Dizziness	Prostate Problems?
[ ] Edema (Swollen legs, ankle or feet)	[ ] Yes
[ ] Fatigue	[ ] No
[ ] Heartburn	
[ ] Irregular Heart Beats or Palpitations	**Are you allergic to any medications?**
[ ] Leg Pain when Walking	[ ] Yes
[ ] Nausea/Vomiting/Abdominal Discomfort	[ ] No
[ ] Shortness of Breath	If yes, please list below:
[ ] Sleep Disorder	
Hospitalization Information	
To Ensure we have accurate records for your visit today, please clearly complete this section.	**Venous Disease Questionnaire**
	Do you have family members with venous disease?
Previous Hospitalizations:	[ ] Yes
Have you been a patient at any hospital within the past six (6) months?	[ ] No
[ ] Yes [ ] No	Do you sit or stand for long period of time?
	[ ] Yes
If yes, which hospital for the first occurrence:	[ ] No
	Do your legs hurt, ache, cramp or feel heavy?
Approximate dates of hospitalization:	[ ] Yes
From:	[ ] No
To:	Do you have swelling in your legs?
	[ ] Yes
Which Hospital for the second occurrence:	[ ] No
	Do you have varicose or spider veins? (visible veins on your legs)
Approximate dates of hospitalization:	[ ] Yes
From:	[ ] No
To:	Do you have skin discoloration below your knees?
	[ ] Yes
Which Hospital for the third occurrence:	[ ] No
	Have you ever had or currently have an ulcer on your legs?
Approximate dates of hospitalization:	[ ] Yes
From:	[ ] No
To:	Have you ever had a blood clot in your legs or pulmonary embolism?
	[ ] Yes
	[ ] No

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