

# Edmonton Cardiology Consultants

#350, 11010 – 101 Street, East Tower Hys Center  
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Date: \_\_\_\_\_

**This form is to be completed before your scheduled appointment with the  
Cardiologist. Please bring it with you to your appointment.**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. Have you ever had a heart attack?  Yes  No
2. Have you had open heart surgery?  Yes  No Indication: \_\_\_\_\_
3. Do you experience chest discomfort?  Yes  No
4. Do you experience shortness of breath?  Yes  No
5. How many pillows do you put behind your head when you go to sleep? \_\_\_\_\_
6. Do you wake up at night short of breath?  Yes  No
7. Do you notice swelling in your ankles or legs?  Yes  No
8. How far can you walk before you get short of breath? \_\_\_\_\_
9. How long do you have to rest before you catch your breath? \_\_\_\_\_  
How far can you walk before needing to stop to rest? \_\_\_\_\_
10. Have you ever completely lost consciousness?  Yes  No  
(Completely unconscious and unresponsive)
11. Do you feel your heart beating irregularly or fluttering?  Yes  No
12. How long does the fluttering or heart racing last? \_\_\_\_\_
13. Have you ever has a stroke / TIA / "mini stroke"?  Yes  No

## **Cardiac Risk Factors**

- Have you ever been diagnosed with Diabetes?  Yes  No
- Have you ever been diagnosed with high blood pressure?  Yes  No
- Have you ever been diagnosed with high cholesterol?  Yes  No
- Do you currently smoke cigarettes?  Yes  No Qty: \_\_\_\_\_
- Are you an ex-smoker?  Yes  No
- Is there a family history of early heart disease?  
(men younger then age 55, women younger then 65)  Yes  No

## **Current Medications (Please list both prescriptions & over the counter drugs) (FILL OUT GREEN SHEET)**

**Allergies** Are you allergic to any medications?  Yes  No  
If yes, please list: \_\_\_\_\_

## **Past Medical & Surgical History:**

### **Social History**

What city/town do you live in? \_\_\_\_\_

Does anyone live at home with you?  Yes (who) \_\_\_\_\_  No

Do you drink alcohol?  Yes (quantity) \_\_\_\_\_  No

Occupational Status: \_\_\_\_\_

If working or retired, what type of work / occupation? \_\_\_\_\_