COMPLETE CARDIOLOGY
Steven J. Eisenberg, MD

Name: **Birthdate: / /** **Age:** **Date: / /**

Referred By: **Primary Care Physician**

Reason for Visit:

Preferred Contact #: **Email:**

Pharmacy Name/Location/Phone #:

Procedure History

	Date	*Results*
Stress Test	_____	_____
Heart Cath	_____	_____
Angioplasty	_____	_____
Bypass Surgery	_____	_____
Leg Artery Surgery	_____	_____
Carotid Surgery	_____	_____

Past Surgeries

Please include procedure dates

_____
_____
_____
_____

Medication Overview

List medications you are currently taking including non-prescription and herbal

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8. _____
9. _____
10._____

Allergies

Are you allergic to latex? ◉ No / Yes ○
Are you allergic to shellfish/iodine? ◉ No / Yes ○
Do you have any drug allergies? ◉ No / Yes ○
If so, please list:

_____
_____
_____

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Atlanta, GA 30342

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Risk Factors

Do you have any of the following?

Diabetes Type 1	◉ No / Yes ○	How Long? _____
Diabetes Type 2	◉ No / Yes ○	How Long? _____
High BP	◉ No / Yes ○	How Long? _____
High Cholesterol	◉ No / Yes ○	How Long? _____

Cholesterol Present Values if known: LDL____ HDL____ Triglycerides_____

Social History

Use of Alcohol: ○Never ○Rarely ○Moderate ○ Daily____
Use of Tobacco: ○Never ○Rarely ○Moderate ○ Daily____
E-cigarette/ Vaping: ○Never ○Rarely ○Moderate ○ Daily____
Use of Drugs: ○Never Type/Frequency_____
Use of Caffeine: ○Never Frequency_____
Exercise: Type/Frequency_____
Number of Children_____

Family Medical History

	Age	Diseases	If deceased, cause of death
Father:			
Mother:			
Brother(s):			
Sister(s):			

Have a great day!

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General	NO	YES	Respiratory	NO	YES
Unexplained weight loss	◉	○	Persistent cough	◉	○
Unexplained weight gain	◉	○	Phlegm	◉	○
Persistent fever	◉	○	Coughing up blood	◉	○
Chills	◉	○	Wheezing	◉	○
Night sweats	◉	○	Asthma	◉	○
Cardiac			Tuberculosis	◉	○
Lung clot	◉	○	Pneumonia	◉	○
Pain in legs when walking	◉	○	Emphysema	◉	○
Stroke	○	○	Snoring	◉	○
TIA (mini stroke)	◉	○	Sleep apnea	◉	○
Loss of consciousness	◉	○	**Gastrointestinal**		
Severe dizziness	◉	○	Heartburn	◉	○
Irregular heart beat	◉	○	Indigestion	◉	○
Rheumatic fever	◉	○	Ulcers	◉	○
Blood clot in leg(s)	◉	○	Unexplained constipation	◉	○
Other heart related issues	◉	○	Unexplained diarrhea	◉	○
Eyes			Blood in stool	◉	○
Glasses/Contacts	◉	○	Black stool	◉	○
Glaucoma	◉	○	Gallbladder	◉	○
Double vision	◉	○	Hepatitis	◉	○
Redness	◉	○	Abdominal pain/cramps	◉	○
Pain	◉	○	Polyps	◉	○
Loss of vision	◉	○	**Psychiatric**		
ENT			Anxiety	◉	○
Hearing loss	◉	○	Depression	◉	○
Ringing in ears	◉	○	Panic disorders	◉	○
Chronic infections	◉	○	Suicidal thoughts	◉	○
Redness	◉	○	Substance abuse	◉	○
Pain	◉	○	**Musculoskeletal**		
Nosebleeds	◉	○	Arthritis	◉	○
Hoarseness	◉	○	Back/Neck/Hip pain	◉	○
False teeth	◉	○	Bursitis	◉	○
Seasonal allergies	◉	○	Sciatica	◉	○
			Joint swelling	◉	○
Genitourinary			**Neurologic**		
Stones	◉	○	Stroke	◉	○
Kidney disease	◉	○	Migraines	◉	○
Blood in urine	◉	○	Seizures	◉	○
Herpes	◉	○	Memory loss	◉	○
HIV/AIDS	◉	○	Numbness/Tingling	◉	○

If yes, please explain:

_____

_____

_____