HEARTWISE

A wholehearted approach to living.™

brought to you by

The DOCTORS Center

Because your healthcare doesn't follow a schedule

Your Appointment is Scheduled For / /

at :

Cancellation Policy:

Please inform us at least 72 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients. Please note that we reserve two hours of time with our staff for your appointment, so late cancellations significantly affect us.

Patients who cancel or reschedule less than 72 hours prior to their appointment will be charged a $200 cancellation fee.

Please contact our office with any questions at (361) 852-6824.

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APPOINTMENT PREPARATION INSTRUCTIONS

1. FASTING
    - Please refrain from eating for eight (8) hours prior to your visit
    - Try to consume minimal water and avoid all other beverages
    - You may take medications with minimal water
    - Please refrain from consuming alcohol for 24 hours prior to your visit
    - You are welcome to bring a snack to eat after the fasting portions of your tests have been completed. We will also have healthy snacks and drinks on hand for you.

2. CLOTHING

    Because part of your visit includes treadmill exercise testing with EKG, you should wear comfortable clothing and shoes. Although gym or "training" attire is not necessary (comfortable work clothes are OK), restrictive clothing should be avoided (no boots, high heels, etc.). Alternatively, we can provide a cover robe for this portion of testing.

3. EYE PREP

    Your appointment will include a photo of the back of your eye. Although we will not dilate your eyes, we will need you to remove your contact lenses for this test. In preparation for this, please bring any equipment you may need to remove your contacts, or wear glasses.

4. MEDICAL HISTORY

    Please fill out as much of the Patient Medical History Form as possible prior to your appointment. Some of the questions regarding family history are critical for formulating an accurate "risk score" and providing a comprehensive medical evaluation, and may require inquiry or research. Our staff will assist you in filling out information you have questions about.

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PATIENT MEDICAL HISTORY

Please complete this form and bring it with you to your appointment. If you have questions or need assistance, we will review this form with you during your visit.

A detailed family medical history can help our medical providers interpret the history of disease in your family and identify patterns that may be relevant to your own health. This form will help assess your risk of certain diseases, determine which diagnostic tests to order as well as type and frequency of screening tests, identify a condition that might not otherwise be considered, and assess your risk of passing a condition on to your children.

1. Demographics

Name_____

Date of Birth_____ **Gender (circle one): Male Female**

Address _____ City _____ State _____Zip_____

Primary Phone (_____) _____ - _____ Alternate Phone (_____) _____ - _____

Email address (kept confidential)_____

2. Social History

Marital status:	☐ Single	☐ Divorced	☐ Married	☐ Widow/Widower	☐ Other_____
Living	☐ Alone	☐ Spouse/partner	☐ Relative	☐ Children	☐ Other_____
Race	☐ Asian	☐ African American	☐ White/Caucasian	☐ Hispanic	☐ Other_____
Occupation:	_____	Job title / description:_____			

Exercise: Do you get 30min of steady physical exertion/exercise 3-4 times per week? □ Yes □ No

Type of activity: □ Walking □ Running □ Jogging
□ Yard work □ Swimming □ Biking
□ Household chores □ Other_____

Do you have physical conditions that limit your ability to exercise? Specify_____

Do you smoke?	☐Never used tobacco	☐ Cigarettes	# per day_____	Number of years_____
	☐Ex-tobacco user	☐ Cigars	# per day_____	Number of years_____
	☐ Currently Use	☐ Pipe	# per day_____	Number of years_____

Alcohol	☐ Yes ☐ No	*If yes, indicate on average how much and check day, week or month:*		
	_____Beer per:	☐ Day	☐ Week	☐ Month
	_____Glasses of wine per:	☐ Day	☐ Week	☐ Month
	_____Mixed drinks per:	☐ Day	☐ Week	☐ Month

Family History Has any blood relative of yours had a heart attack or stroke before the age of 60? ☐ Yes ☐ No

Personal History Have you ever had a heart attack, stroke, stent, cath lab procedure or surgery involving your heart? ☐ Yes ☐ No

3. Personal History

Please check any of the conditions that you currently have or have had in the past.

	YES	NO	Explain		YES	NO	Explain
Fever or chills				**Skin**			
Recent weight change				Rash, dryness, itching			
Fatigue				Change in nails or skin color			
Heat or cold intolerance				Bleeding, bruising tendencies			
Recent changes in mood				**Cardiovascular**			
Head and Neck				High blood pressure			
Swelling in neck				High Cholesterol			
Prolonged hoarseness				Diabetes			
Frequent sore throat				Heart failure			
Pain or stiffness in neck				Heart murmur			
Eyes				Chest pain or Angina			
Glasses or contacts				Heart skips beats			
Double, failing vision				Heart beats too fast			
Dry eyes				Passing out spells			
Pain or light sensitivity				Rheumatic fever			
Ears, Nose, Mouth				Feet, ankle or leg swelling			
Loss of smell				Short of breath at rest			
Nose bleeds				Short of breath with exercise			
Sinus Problems				Short of breath lying down			
Runny Nose				Problems sleeping			
Postnasal drip				Sexual dysfunction			
Earache or drainage				Frequent urination			
Hearing loss				Abdominal pain			
Ringing in ears				**Lungs**			
Sores in mouth				Cough with sputum or blood			

	YES	NO	Explain		YES	NO	Explain
Wheezing				Kidney stones			
Asthma				Irregular menses (female only)			
Musculoskeletal				**Gastrointestinal**			
Swollen or red joints				Rectal bleeding			
Poor leg circulation				Blood in stool			
Arm or leg weakness				Loss of appetite			
Leg cramps				Heartburn or indigestion			
Difficulty in walking				Black or tarry stools			
Arthritis				Frequent diarrhea			
Inflammatory Disease (i.e. psoriasis)				Difficulty swallowing			
Neurologic				Nausea or vomiting			
Light head or dizziness				Vomiting of blood			
Speech disturbances				Chronic constipation			
Convulsions or seizures				Stomach ulcer			
Numbness or tingling				**Endocrine**			
Frequent headaches				Night sweats			
Memory loss				Excessive thirst			
Paralysis or weakness				**Psychiatric**			
Genitourinary				Depression			
Burning or painful urination				Anxiety			
Blood in urine				Nervous breakdown			
Bladder infections				Alcohol problems			
Incontinence, dribbling				Physical, verbal, sexual abuse			

Please include any other conditions you would like to discuss with our medical provider:

_____

_____

_____

4. Weight / Dieting History

Do you want to change your eating habits?	□ Yes	□ No	Why?
Have you tried to lose weight before?	□ Yes	□ No	How many times? _____
Are you currently on a special diet?	□ Yes	□ No	Specify_____
Have you used any diet programs in the past?	□ Yes	□ No	
If so, which ones:_____			
What was your weight at age 20?	_____(in lbs)		
Are members of your family overweight?	Explain: _____		

Fill in the box of the number closest to your best estimate of servings per day:

Foods with fat/cholesterol (fried foods, fatty meats, junk food)	□ 0	□ 1	□ 2	□ 3	□ 4 or more
Fruits and vegetables (4 cup cooked, 1 cup raw)	□ 0	□ 1	□ 2	□ 3	□ 4 or more
Caffeine (1 cup coffee, soda etc.)	□ 0	□ 1	□ 2	□ 3	□ 4 or more
Calcium servings (dairy foods, 8 oz. milk, yogurt, cheese, ice cream)	□ 0	□ 1	□ 2	□ 3	□ 4 or more

5. What Past Surgeries, Procedures & Diagnostic Tests Have You Had?

List past testing, hospital visits & surgeries (For example: stent, cath procedure, heart surgeries, exercise tests, heart scan, MRI, CT scan etc.)
PLEASE DO NOT WRITE "My physician has copies of all tests"

Surgery Type / Diagnostic Test	Current or Past Problem (Circle one)		Date of Surgery or Diagnostic Test	Physician or Hospital Where Procedure Took Place
Example: Brain surgery	**Yes**	**No**	**May 11, 1999, May 1999**	**N/A or Currently being treated**
Stent	**Yes**	**No**		
Cath Procedure or Angiogram	**Yes**	**No**		
	Yes	**No**		
	Yes	**No**		
	Yes	**No**		
	Yes	**No**		

Comments/Notes:

6. Allergies

List allergies & type of reaction. Include medications, food, & seasonal & environmental allergies (For example: animals, latex, smoke, etc.)

☐ **No Known Allergies or Never Been Diagnosed with Any Allergies**

Allergy to	Description of Reaction	Allergy to	Description of Reaction
Example: Water allergy	**Hives and rash**	**3.**	
1.		**4.**	
2.		**5.**	

7. What Past & Current Medical Problems ("Diagnoses") Do You Have or Are You Being Treated For?

List all medical problems for which you are currently being treated or have previously been treated. Include all diseases and illnesses you have been told you have or are being treated for.

Condition	Current Problem or Being Treated For (Circle one)		Date When First Diagnosed	Date When Resolved or stopped taking medications or stopped being treated for
Example: Psoriasis	**Yes**	**No**	**June 14, 1996 or June 2006**	**N/A or Currently being treated**
Diabetes (only if taking medications)	**Yes**	**No**		
High Blood Pressure	**Yes**	**No**		
Cholesterol	**Yes**	**No**		
	Yes	**No**		
	Yes	**No**		
	Yes	**No**		
	Yes	**No**		

8. List All Medications You Are Taking Here

List type and amount of medication you use on a regular basis. Include prescription, over-the-counter, birth control, hormones, vitamins, herbs, nutritional supplements and recreational drugs.

Medication	Dosage/Frequency	Reason for taking	Started: Mo/Yr
Example: Aspirin	50mg once per day	Prevention	March 2005

9. Family History

Please complete as much of this section as possible. You can also bring your family history with you and we will enter the information into the chart below for you.

Adopted ☐ Yes ☐ No

Medical Condition	**Mom**	**Dad**	**Sister**	**Brother**	**Daughter**	**Son**	**Grandparents MGF / MGM PGF / PGM**	**Comments**
Indicate approximate age disease first identified:								
High blood pressure	age	age	age	age	age	age	age	
↑ Lipids/ cholesterol	age	age	age	age	age	age	age	
Diabetes (type 1/type 2)	age	age	age	age	age	age	age	
Heart Attack	age	age	age	age	age	age	age	
Heart Failure	age	age	age	age	age	age	age	
Heart surgery/stent/balloon	age	age	age	age	age	age	age	
Angina (heart pain)	age	age	age	age	age	age	age	
Leg circulation problem	age	age	age	age	age	age	age	
Failing kidneys	age	age	age	age	age	age	age	
Stroke	age	age	age	age	age	age	age	
Smoking	age	age	age	age	age	age	age	
Dementia / Alzheimer's	age	age	age	age	age	age	age	
Alcoholism	age	age	age	age	age	age	age	
Arthritis	age	age	age	age	age	age	age	
Birth defects	age	age	age	age	age	age	age	
Hearing problems	age	age	age	age	age	age	age	
Sudden death	age	age	age	age	age	age	age	
Genetic Diseases	age	age	age	age	age	age	age	
Age & L=Living D=Deceased	**Mom**	**Dad**	**Sister**	**Brother**	**Daughter**	**Son**	**Grandparents MGF _____ MGM_____ PGF _____ PGM _____**	**Comments**
*MGF = Maternal Grandfather; MGM = Maternal Grandmother; PGF = Paternal Grandfather; PGM = Paternal Grandmother								

Please include any other details related to your family history or concerns you would like to discuss with our specialists:

_____

_____

_____

_____

_____

_____

_____

4833 South Staples Drive | Corpus Christi, TX 78411 | (361) 852-6824

10. Phase of Life (Women ONLY): Check all boxes that apply to you

Date of Last Menstrual Period (LMP): _____			
Menopause:	☐ I am pre-menopausal	☐ Experiencing menopause	☐ Other/NA _____

Please indicate below specific health concerns, information you would like to receive or particular questions you have:

_____

_____

_____

_____

_____

_____

11. How Did You Hear About Us?

Heard of Center From	✓	Heard of Center From	✓
Physician referral		**Television**	
Radio		**Internet**	
Print advertisement		**Word of mouth**	
Mailing		**Other**	

Specify: _____

Would you like us to send your results to another health care provider? ☐ **Yes** ☐ **No**

♦**If so, we will need his or her first and last names and complete address.**

Provider's name: _____

Clinic name: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone (_____) _____ Fax: (_____) _____

Signature: _____

Internal Purposes Only

History reviewed by: _____

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STRESS QUESTIONNAIRE

Please consider the following conditions and answer the questionnaire in an honest manner. Circle the number which shows how regularly you have experienced the symptom during the last six months.

	NEVER	SELDOM	SOMETIMES	OFTEN	REGULAR
Heart pounding or racing	0	1	2	3	4
Trembling/shaking	0	1	2	3	4
Grinding of teeth (even in your sleep)	0	1	2	3	4
Do not sleep well	0	1	2	3	4
Susceptible to illness	0	1	2	3	4
Stomach pains	0	1	2	3	4
Headaches	0	1	2	3	4
Migraine headaches	0	1	2	3	4
Feeling tired constantly	0	1	2	3	4
Constipation	0	1	2	3	4
Hollow stomach	0	1	2	3	4
Lowered self-confidence	0	1	2	3	4
Loss of appetite	0	1	2	3	4
Excessive sweating (e.g. hands, face, arm pts, etc.)	0	1	2	3	4
Sweaty palms	0	1	2	3	4
Listlessness - don't feel like doing stuff	0	1	2	3	4
Forget things	0	1	2	3	4
Absentminded	0	1	2	3	4
Feeling irritated	0	1	2	3	4
Nauseous	0	1	2	3	4
Considered suicide	0	1	2	3	4
Pessimistic	0	1	2	3	4
Jealous/Envious	0	1	2	3	4
Moody	0	1	2	3	4
Pain in the lower back	0	1	2	3	4
Feelings of depressions	0	1	2	3	4
Anxiety	0	1	2	3	4
Loss of interest in things	0	1	2	3	4
Sensitive and/or Touchy	0	1	2	3	4
Muscle pain	0	1	2	3	4
Indecisive	0	1	2	3	4
Unnecessary/excessive checking of work	0	1	2	3	4
Difficulty with breathing	0	1	2	3	4
Struggle to overcome minor sicknesses (eg. a cold)	0	1	2	3	4
Suspicious	0	1	2	3	4
Hair loss	0	1	2	3	4

	NEVER	SELDOM	SOMETIMES	OFTEN	REGULAR
Throat irritations	0	1	2	3	4
Lost sense of humour	0	1	2	3	4
Impaired concentration	0	1	2	3	4
Struggle to lose/gain weight even when following a diet	0	1	2	3	4
Heartburn	0	1	2	3	4
Skin disorders	0	1	2	3	4
Don't take initiative as you used to	0	1	2	3	4
Nightmares	0	1	2	3	4
Dry mouth	0	1	2	3	4
Consumption of energy drinks (i.e. Red Bull, 5-Hour Energy, Rockstar, etc.)	0	1	2	3	4
Diarrhea	0	1	2	3	4
Nervous twitches in face or scalp	0	1	2	3	4
Feelings of inadequacy	0	1	2	3	4
Easily startled/jumpy	0	1	2	3	4
Increased appetite	0	1	2	3	4
Impaired co-ordination	0	1	2	3	4
Uncertainty	0	1	2	3	4
Become frustrated quickly	0	1	2	3	4
Less involvement with others	0	1	2	3	4
Biting of fingernails	0	1	2	3	4
Reduced motivation	0	1	2	3	4
Increased caffeine intake (coffee, tea, coke, coke light, etc.)	0	1	2	3	4
Restlessness	0	1	2	3	4
Poor judgment	0	1	2	3	4
Increased smoking	0	1	2	3	4
Feeling out of control	0	1	2	3	4
Confused thoughts	0	1	2	3	4
Increased time sleeping	0	1	2	3	4
Use tranquilizers, sleeping pills	0	1	2	3	4
Waking up tired	0	1	2	3	4
Feeling overwhelmed by demands	0	1	2	3	4
Excessive blinking	0	1	2	3	4
Daydreaming	0	1	2	3	4
Procrastination	0	1	2	3	4
Feeling panicky	0	1	2	3	4
Reduced productivity	0	1	2	3	4
Wasting time on irrelevant activities	0	1	2	3	4
Cannot discuss my problems with others	0	1	2	3	4
Difficult to identify causes of nonperformance	0	1	2	3	4
Internal Purposes Only					
Total Score (add totals from boxes to right and insert here):					