Florida Cardiopulmonary Center
Central Florida Cardiovascular Consultants, P.L.

Florida Amputation Prevention Institute

RATAN K. AHUJA, MD, FACC, FSCAI
Assistant Professor, UCF College of Medicine
DAVID JOSEPH, MD, FACC
HARVINDER ARORA, MD, MPH
NATASHAH.TULSHI, MSN, ACNP-BC
JENNIFER ELROD, MSN, APRN
ANJALI CHANDRASHEKAR, MSN, ARNP-BC, NP-C

PLEASE FILL OUT ALL PAGES AS COMPLETELY AS POSSIBLE.

Name_____ Date of Birth_____Age_____

Date_____ Referring Physician_____

CHIEF COMPLAINTS:

_____

_____

PAST MEDICAL HISTORY (HAVE YOU HAD THESE?)

CARDIAC:

Coronary Artery Disease YES____NO_____
Heart Attack YES____NO_____
Coronary Artery Stent YES____NO_____
Heart Catheterization YES____NO_____
Heart Bypass Surgery YES____NO_____
Hypertension YES____NO_____
Congestive Heart Failure YES____NO_____

ENDOCRINE:

Diabetes YES____NO_____
High Cholesterol YES____NO_____
Hypothyroidism YES____NO_____
Hyperthyroidism YES____NO_____

NEOROLOGICAL:

Stroke YES____NO_____
Epilepsy YES____NO_____

VASCULAR:

Peripheral Vascular Disease YES_____NO
Carotid Artery Disease YES_____NO
Varicose Veins YES_NO_____

RESPIRATORY:

Bronchial Asthma YES____NO_____
Pneumonia YES____NO_____
Emphysema YES____NO_____
Lung Cancer YES____NO_____
Sleep Apnea YES____NO_____

GASTRINTESTINAL:

Peptic Ulcer Disease YES____NO_____
Hepatitis YES_____NO
Irritable Bowel Syndrome YES___NO_____
Ulcerative Colitis YES_NO_____
Crohn's Disease YES____NO_____

UROLOGICAL:

Kidney Stones YES_____NO
Chronic Kidney Disease YES_____NO
Benign Prostatic Hypertrophy YES_NO_____

OTHERS:

Arthritis YES____NO_____
Bleeding Disorders YES____NO_____
Cancer YES____NO_____

LIST ANY OTHER DISEASES:

_____

_____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

_____

_____

ALLERGIES (TO THE FOLLOWING MEDICATIONS, PLEASE CHECK)

PENICILLIN_____SULFA_____ASPRIN_____SHELLFISH_____IV DYE_____

OTHER MEDICATIONS:

_____

PLEASE SPECIFY REACTION TO ABOVE MEDICATIONS: _____

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

FAMILY MEDICAL HISTORY (Has any blood relative ever had?)

	YES	NO	WHO		YES	NO	WHO
Diabetes	_____		_____	Cancer	_____	_____	_____
High Blood Pressure	_____	_____	_____	Stroke	_____	_____	_____
Heart Disease	_____	_____	_____	Abnormal Bleeding	_____	_____	_____

SOCIAL HISTORY

Female Patients: Are you pregnant or do you think you are pregnant? YES_____NO_____

Married_____Single_____ Divorced_____Widowed_____Separated_____

TOBACCO USE

Are your currently using tobacco? YES_____NO_____#packs per day_____for how many years_____

How long after you wake up do you smoke your first cigarette? _____

How ready you are to quit? (check one)_____Ready to quit?_____Thinking about quitting? _____

Not ready to quit? Did you use tobacco in the past? YES_____NO_____# packs per day_____for how many years_____

Date you quick_____

ALCOHOL USE

Do you use alcohol regularly? YES_____NO_____How much per day for how many years? Did you use tobacco in the past? YES_____NO_____How much per day for how many?_____Date you quit_____

Exercise

Do you exercise regularly? YES_____NO_____How much?_____

REVIEW OF SYSTEMS

CARDIAC:

Shortness of Breath	YES____ NO_____
Chest Pain	YES_____NO_____
Heart Palpitations	YES_____NO_____
Dizziness, Fainting	YES_____NO_____
Ankle Swelling	YES_____NO_____

ENDOCRINE:

Excessive Thirst	YES_____NO_____
Increased Urination	YES_____NO_____
Heat or Cold Intolerance	YES_____NO_____
Rising to void, more than once per night	YES_____NO_____

NEUROLOGICAL:

Severe Headaches	YES____ NO_____
Confusion	YES_____NO_____
Weakness in Arm/Leg	YES____ NO_____
Transient Blindness	YES_____NO_____

VASCULAR:

Calf Pain on Ambulation	YES_____NO_____
Numbness/ Tingling in Feet	YES_____NO_____

RESPIRATORY:

Cough	YES____ NO_____
Spitting of Blood	YES_____NO_____
Wheezing	YES_____NO_____

GASTROINTESTINAL:

Abdominal Pain or Heartburn	YES_____NO_____
Nausea, Vomiting	YES_____NO_____
Diarrhea	YES_____NO_____
Constipation	YES_____NO_____

GENERAL REVIEW:

Weight Change	YES_____NO
Extreme Fatigue	YES_____NO
Fever	YES_NO_____
Joint Pains	YES_____NO____
Excessive Bruising	YES____ NO_____
Impaired Sight	YES____ NO_____
Nose Bleed	YES_____NO_____
Anxiety	YES____ NO____