COMPLETE CARDIOLOGY
Steven J. Eisenberg, MD

Please Complete All Pages

Office Visit Questionnaire

Name: Birth Date: / / Age: Today's Date: / /

Referred By: Primary Care Physician:

Reason for Visit:

Preferred Contact #: Email:

Pharmacy Name/Location/Phone Number:

Past Cardiovascular History

Have you ever had any of the following?

Heart attack	No / Yes	Stroke	No / Yes
Angina	No / Yes	TIA (mini-stroke)	No / Yes
Congestive heart failure	No / Yes	Loss of Consciousness	No / Yes
Enlarged Heart	No / Yes	Severe dizziness	No / Yes
Abnormal EKG	No / Yes	Irregular heart beat	No / Yes
Murmur	No / Yes	Rheumatic Fever	No / Yes
Lung Clot	No / Yes	Blood Clot in leg(s)	No / Yes
Pain in legs when walking	No / Yes	Other heart-related issues	No / Yes

Procedure History

Please Update Changes Since Last Annual Exam

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

Risk Factors

Do you have the following?

Diabetes Type 1	No / Yes	How long?
Diabetes Type 2	No / Yes	How long?
High Blood Pressure	No / Yes	How long?
High Cholesterol	No / Yes	How long?

Present values, if known: Cholesterol

HDL LDL Triglycerides

Medication Overview

Please Update Changes Since Last Annual Exam

List medications you are currently taking including non-prescription / herbal:

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

Any Previous Surgeries? If so, please list:

Are you allergic to latex? No / Yes

Are you allergic to shellfish/iodine? No / Yes

Do you have any drug allergies? If so, please list:

Social History

Use of Alcohol:	Never	Rarely	Moderate	Daily:
Use of Tobacco:	Never	Previously but quit		Daily:
Use of Drugs:	Never	Type/Frequency:		
Use of Caffeine:	Never	Frequency:		

Exercise: Type/Frequency:

# of Children:

(Please Update Changes Since Last Annual Exam)

Systems Review

Have you ever had or currently have any of the following?

General:					
Weight Loss	No / Yes	Weight Gain	No / Yes	Chills	No / Yes
Fever	No / Yes	Night Sweats	No / Yes		
Eyes:					
Glaucoma	No / Yes	Double Vision	No / Yes	Pain	No / Yes
Glasses/Contacts	No / Yes	Redness	No / Yes	Loss in Vision	No / Yes
ENT:					
Hearing loss	No / Yes	Ringing in Ears	No / Yes	Infections	No / Yes
Pain	No / Yes	Redness	No / Yes	Nosebleeds	No / Yes
Hoarseness	No / Yes	False Teeth	No / Yes	Seasonal allergies	No / Yes
Pulmonary/Respiratory:					
Cough	No / Yes	Phlegm	No / Yes	Coughing up blood	No / Yes
Wheezing	No / Yes	Asthma	No / Yes	Tuberculosis	No / Yes
Pneumonia	No / Yes	Emphysema	No / Yes	Snoring	No / Yes
Sleep Apnea	No / Yes				
Gastrointestinal					
Heartburn	No / Yes	Indigestion	No / Yes	Ulcers	No / Yes
Constipation	No / Yes	Diarrhea	No / Yes	Blood in Stool	No / Yes
Black Stool	No / Yes	Gallbladder disease	No / Yes	Hepatitis	No / Yes
Abdominal Pain	No / Yes	Polyps	No / Yes		
Psychiatric:					
Anxiety	No / Yes	Depression	No / Yes	Panic disorders	No / Yes
Suicidal thoughts	No / Yes	Drugs/alcohol abuse	No / Yes		
Musculoskeletal:					
Arthritis	No / Yes	Back/Neck/Hip pain	No / Yes	Bursitis	No / Yes
Sciatica	No / Yes	Joint Swelling	No / Yes		
Neurologic:					
Strokes	No / Yes	Migraines	No / Yes	Frequent headaches	No / Yes
Seizures	No / Yes	Memory Loss	No / Yes	Numbness/Tingling	No / Yes
Genitourinary:					
Stones	No / Yes	Kidney disease	No / Yes	Blood in urine	No / Yes
Herpes	No / Yes	HIV/AIDS	No / Yes		

Other:

Family Medical History **(Please Update Changes Since Last Annual Exam)**

☐ ***Check here if there are no changes since your last visit.***

	Age	Diseases	If Deceased, Cause of Death
Father:			
Mother:			
Brother:			
Sister:			