New Patient Referrals on
par80, Crimson or Fast Track:

*referrals@faxes.ohanacardiology.com*
*eFax* 480-452-1486

'Ohana CARDIOLOGY

3420 S. Mercy Rd., Ste. 300 Gilbert, AZ 85297
480-955-0900 480-955-0800 *OhanaCardiology.com*

Michael D. Barry, DO., FACC
Interventional Cardiology

## PATIENT CURRENT SYMPTOMS - REVIEW OF SYSTEMS

*Do you currently have or recently have had any of the following symptoms? Provide to staff.*

### CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Chest Discomfort
- ☐ Fluttering Feeling in Chest
- ☐ Skipped Heart Beats/Palpitations
- ☐ Swelling in Ankle/Feet
- ☐ Varicose Veins

### INTEGUMENTARY
- ☐ Skin Rash
- ☐ Skin Ulcers
- ☐ Non-Healing-Wounds

### NEUROLOGICAL
- ☐ Headaches/Migraines
- ☐ Memory Loss
- ☐ Speech Problems
- ☐ Dizziness/Fainting Spells
- ☐ Neuro Stroke

### GASTROINTESTINAL
- ☐ Loss of Bladder Control
- ☐ Blood In Urine

### HEMATOLOGY/HEPATIC
- ☐ Breast Masses/Lumps
- ☐ Enlarged Lymph Nodes
- ☐ Unexplained Bruising

### MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Leg Pain

### EAR/NOSE/MOUTH/THROAT
- ☐ Difficulty Swallowing
- ☐ Dry/Hoarse Throat

### PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ High/Unusual Stress
- ☐ Eating Disorder

### CONSTITUTIONAL
- ☐ Significant Weight Loss
- ☐ Significant Weight Gain
- ☐ Night Sweats
- ☐ Unexplained Fever

### ENDOCRINE
- ☐ Thyroid Problem

### EYES
- ☐ Blurred/Double Vision
- ☐ Cataracts
- ☐ Glaucoma

### RESPIRATORY
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ History of Tuberculosis
- ☐ Valley Fever
- ☐ Lung Disease

**PATIENT SIGNATURE:** *please sign* _____ **DATE:** _____

## PATIENT MEDICAL HISTORY AND RISK FACTORS

*Please check all medical issues you have or recently have had in the past?*

### MEDICAL ISSUES

- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Renal Kidney Failure
- ☐ Lung Disease
- ☐ Intestinal Disease
- ☐ Thyroid Disease
- ☐ Asthma/Emphysema
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Diabetes
- ☐ Anesthesia Problems
- ☐ Valley Fever/TB
- ☐ Drug Abuse
- ☐ Cancer *please list type:* _____

### WOMEN'S CARDIOVASCULAR HEALTH

- ☐ Have you had a total hysterectomy?
- ☐ Do you take Birth Control Pills?
- ☐ Have you gone through Menopause?
- ☐ Are you taking hormone replacements?
- ☐ Pain or discomfort in the chest, in left arm, or back
- ☐ A faster heartbeat
- ☐ Irregular heartbeats (skipped beats, flip-flop feeling in your chest)
- ☐ Shortness of breath
- ☐ Nausea and/or vomiting
- ☐ Sudden sweating or sweating when there is no real cause (cold, clammy feeling)
- ☐ Light-headedness or Dizziness
- ☐ Neck, jaw, shoulder, upper-back or abdominal discomfort
- ☐ Unusual Fatigue
- ☐ Extreme weakness
- ☐ Indigestion

### SOCIAL HABITS

Do you or have you?

- ☐ Use Tobacco — How often? _____ When did you quit? _____
- ☐ Drink Alcohol — How often? _____ When did you quit? _____
- ☐ Drink Caffeine — How often? _____ when did you quit? _____
- ☐ Take Illicit Drugs? — How often? _____ When did you quit? _____

List any problems with mobility or self-care: _____

_____

_____

## SURGICAL PROCEDURES AND OPERATIONS HISTORY

### PROCEDURES & SURGERIES *List type of procedure and mm/yy performed:*

- ☐ Heart Surgery
- ☐ Vascular Surgery
- ☐ Cardiovascular Procedures/Interventions
- ☐ Other Surgeries

Procedure _____ Date *(mm/yy)* _____

Procedure _____ Date *(mm/yy)* _____

Procedure _____ Date *(mm/yy)* _____

Procedure _____ Date *(mm/yy)* _____

Procedure _____ Date *(mm/yy)* _____

Procedure _____ Date *(mm/yy)* _____

Procedure _____ Date *(mm/yy)* _____

### DEVICE IMPLANT INFORMATION *Include Type, Serial # and Implant Date*

Type: _____ Serial Number _____ Implant Date: _____

Type: _____ Serial Number _____ Implant Date: _____

Type: _____ Serial Number _____ Implant Date: _____

**PATIENT SIGNATURE:** *please sign* _____ **DATE:** _____

## PATIENT FAMILY HISTORY AND RISK FACTORS

*Please check all medical issues in your immediate family, biological family such as parents, grandparents, brothers and sisters.*

☐ Heart Disease Who? Please list_____

☐ High Blood Pressure Who? Please list_____

☐ Bleeding Disorders Who? Please list_____

☐ Renal/Kidney Failure Who? Please list_____

☐ Lung Disease Who? Please list_____

☐ Heart Murmur Who? Please list_____

☐ Stroke Who? Please list_____

☐ Diabetes Who? Please list_____

☐ Valley Fever/TB Who? Please list_____

☐ Cancer Who and what type(s)? _____

Are you currently enrolled in Pain Management? ☐ Yes ☐ No

Provider Name _____ Clinic Name _____

Clinic Phone _____ Clinic Address _____

☐ I have filled out my personal medical history including past family medical history to the best of my abilities.

**PATIENT SIGNATURE:** *please sign* _____ **DATE:** _____