

HEARTWISE

A wholehearted approach to living.™

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 (512) 462-DOCS (3627).

HEARTWISE Raffle Slip

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Name: _____

E-mail Address: _____@_____.com

Best Phone Number: (_____) _____ - _____

Best way to be contacted (Circle One): Call Text E-mail

Victory Medical – Westlake

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APPOINTMENT PREPARATION INSTRUCTIONS

1. FASTING

- Please refrain from eating for eight (8) hours prior to your visit
- Avoid consuming all beverages except for water
- Take your normal medications with 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

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PATIENT NAME: _____ PATIENT DOB: _____

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			

PATIENT NAME: _____ PATIENT DOB: _____

	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:

PATIENT NAME: _____ PATIENT DOB: _____

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: _____		
<i>Fill in the box of the number closest to your best estimate of servings per day:</i>			
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.	

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PATIENT NAME: _____ PATIENT DOB: _____

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

PATIENT NAME: _____ PATIENT DOB: _____

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
<i>Indicate approximate age disease first identified:</i>								
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:

PATIENT NAME: _____ PATIENT DOB: _____

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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PATIENT NAME: _____ PATIENT DOB: _____

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

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PATIENT NAME: _____ PATIENT DOB: _____

	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
<i>Internal Purposes Only</i>					
Total Score (add totals from boxes to right and insert here):					

Name: _____ Age _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No
If so what type? _____
How old were you when diagnosed? _____

Any other personal cancer history or colon polyps (if so, how many and when found): _____

What country did your mother's family come to the USA from? _____
What country did your father's family come to the USA from? _____

Do you have any Ashkenazi Jewish ancestry? ☐ Yes ☐ No

FAMILY HISTORY:

			Had Cancer?	Type of cancer:	Age at Diagnosis:
Mother:	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
Father:	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____

Do you have children? ☐ Yes ☐ No (If not you may skip to the next box)

	Relation:		Had Cancer?	Type of cancer:	Age at Diagnosis:
1.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
2.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
3.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
4.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
5.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
6.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
7.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
8.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
9.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____

Do you have siblings? ☐ Yes ☐ No (If not you may skip to the next box)

	Relation:		Had Cancer?	Type of cancer:	Age at Diagnosis:
1.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
2.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
3.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
4.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
5.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
6.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
7.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
8.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____
9.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes ☐ No	_____	_____

Do you have nieces or nephews? ☐ Yes ☐ No (If not you may skip to the next box)

Relation: Child of which # sibling?
(From the Box Above)

Had Cancer?

Type of cancer

Age at
Diagnosis:

1.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
2.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
3.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
4.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
5.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
6.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
7.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
8.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
9.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
10.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
11.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
12.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
13.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
14.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____

Do you have aunts and uncles? ☐ Yes ☐ No (If not you may skip to the next box)

If your aunt/uncle is your parent's half sibling please indicate so at the end of this form

Relation:

Had Cancer?

Type of cancer:

Age at Diagnosis:

1.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
2.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
3.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
4.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
5.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
6.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
7.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
8.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
9.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
10.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
11.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
12.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
13.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
14.	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____

Grandparents:

Had Cancer?

Type of cancer: Age at Diagnosis:

Mother's mother:	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
Mother's father:	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
Father's mother:	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____
Father's father:	☐ Living- age: _____	☐ Deceased- age at death: _____	☐ Yes	☐ No	_____	_____

Anyone else *with cancer* you may have missed: (cousins, great grandparents, great aunts/uncles, etc.)

Please state how you are related, for example: "aunt #4's daughter" "maternal grandmother's brother" _____

How are you related:

Type of cancer: Age at Diagnosis:

_____	☐ Living- age: _____	☐ Deceased- age at death: _____	_____	_____
_____	☐ Living- age: _____	☐ Deceased- age at death: _____	_____	_____
_____	☐ Living- age: _____	☐ Deceased- age at death: _____	_____	_____
_____	☐ Living- age: _____	☐ Deceased- age at death: _____	_____	_____
_____	☐ Living- age: _____	☐ Deceased- age at death: _____	_____	_____

Any other important information clinical information:
