Metro North Cardiovascular Associates, P.A.

Max Garoutte, M.D.

Patient Name: ________________________________ D.O.B.:____________________

Reason(s) for Office Visit:

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____

Name of Preferred Pharmacy: ________________________________ Phone#: __________________

Location/City/Zip code: ____

What medication(s) are you allergic to and what was your reaction to the drug: ______________________

____

Please list all prescription medications that you are currently taking. Also list all vitamins, minerals and over the counter medications such as Advil, Aspirin, Laxatives, Allergy medicines, etc.

Name of Medication	Dose/Mg/Unit	How many tablets per day?	Reason

List all Surgeries (From birth to present day), including dates or approximate dates, if available:

____

____

____

METRO NORTH CARDIOVASCULAR & ASSOCIATES, P.A

Patient Symptom Check List

Today's Date:______________________

Patient Name:______________________________ **Date of Birth:** ___________________

Please check any of the following new or ongoing symptoms that apply to you:

1.) Are you or have you been experiencing Chest Pain?: Yes___ or No___. Patient denies chest pain ______(Patient Initial)

Type of Pain:
Achy/Gnawing___.Burning___Tightness___Sharp___Squeezing___Heaviness___Pressure___Indigestion-Like___Tearing or Ripping___

Onset/Timing (When did it begin): Suddenly___ Gradually___ Intermittently(Comes and goes)___

How long has it been happening: ___Day(s) ago. Today___ Yesterday___ ___Week(s) ago ___Month(s) ago Greater than 6 months ___Greater than one year___

Location: Center of chest___ Left side of chest___ Right side of chest___ Neck/Jaw___ Shoots across chest___ Mid-Epigastric___ Infrascapular (Between Shoulder Blades)___ Arm Pain___ Which Arm ________

Quality/Course: Continuous___ Intermittent___ Acute___ Chronic___

Intensity/Severity: Scale of symptoms from 1-10 (1=Slight 10=Severe) 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Mild___ Moderate___ Severe___.

When do you feel the chest pain? While Sleeping___ A rest___ When Stressed___ With exertion___ Climbing stairs___ With Palpitations___ Other: ____.

Accompanied By: Fainting or Dizziness__ Headache__ Nausea/Vomiting__ Rapid or irregular heartbeat__ Shortness of breath__ Unexplained fatigue__ Sweating__.

2.) Are you or have you been experiencing any Shortness of Breath?: Yes___ or No___. Patient denies shortness of breath______ (Patient Initial)

Triggered or worsened By: Mild to moderate exertion___ Smoking___ When stressed___ Walking up stairs___ While at rest___ Walking___ Chest pain___ Palpitations___

Accompanied By: Chest Pain, tightness or discomfort__ Irregular or rapid heartbeat__ Fainting or Dizziness___ Fatigue or Weakness__ Swelling of legs, ankles or feet__ , If so, which? Right leg__ Left leg__ Sweating__

Intensity/Severity: Mild___ Moderate___Severe___

Do you have a history of any of the following: Asthma__ COPD__ Emphysema__ Use of Supplemental Oxygen__ Atrial Fibrillation__ Cardiac Arrhythmia__ Sleep Apnea__ , If so do you use a CPAP Yes__ No__. Autopap Yes__ No__. Mouth Guard Yes__ No__. Pacemaker__

3.) **Are you or have you been experiencing any Palpitations?**: Yes__ or No__. Patient denies feeling any palpitations ________ (Patient Initial)

My heart rate feels: Faster than normal___ Slower than normal___ Irregular/Unsteady___ Flip/Flop___ Flutters___ Spasms___ **When does it occur :** While at rest__ When stressed__ Laying down__ Sleeping__ With or after exertion__ Other: ________________________.

Location: Right side of chest__. Center of chest__. Left side of chest__. Throat__. **Intensity/Severity:** Mild___ Moderate___ Severe___. **How long has it been happening:** ___Day(s) ago. Today___ Yesterday___ ___Week(s) ago ___Month(s) ago Greater than 6 months ___Greater than one year___

Intensity/Severity: Mild___ Moderate___Severe___

Accompanied By: Chest Pain or discomfort__ Shortness of Breath__ Dizziness or lightheadedness__

Do you use any of the following: Caffeine (Tea, Sodas, Coffee or Chocolates)___, if so, how many cups per day?_______ Cigarettes___, if so how many per day?________________. Recreational drugs___, If so, which? _________________ Steroids__ Inhalers__ Nebulizer Treatments__

4.) **Are you or have you been experiencing any Dizziness?**: Yes__ or No__. Patient denies feeling any dizziness ________ (Patient Initial)

Symptoms Feel like: A Spinning sensation___ Unsteady__ Faint__ Lightheaded__ Other:_________________.

Accompanied By: Headache__ Blurred or double vision__ Chest Pain or discomfort__ Facial Numbness__ Nausea__ Irregular Heart beat__ Ringing in ear__ Trouble concentrating__ Memory Loss__

Intensity/Severity: Mild___ Moderate___Severe___

How long has it been happening?: ___Day(s) ago. Today___ Yesterday___ ___Week(s) ago ___Month(s) ago Greater than 6 months ___Greater than one year___ **Triggered or worsened by:** A change in body position__ Turning of the head__ Other____

5.) **Are you or have you been experiencing any fatigue?** Yes__ or No__. Patient denies feeling any fatigue ________ (Patient Initial)

Intensity/Severity: Mild__ Moderate__ Severe__ **Do you sleep well: Y__N__ Average number of hours spent sleeping per night: ______.**

Does your fatigue keep you from performing any daily activities? Y__N__ Explain:

____

____.

6.) **Are you or have you been experiencing any edema(swelling)?** Yes__ or No__. Patient denies feeling any edema________ (Patient Initial)

Please specify location (be specific): ____________________________________.

How long has it been happening?: ___Day(s) ago. Today___ Yesterday___ ___Week(s) ago ___Month(s) ago Greater than 6 months ___Greater than one year___ **Intensity/Severity:** Mild__ Moderate__ Severe__

Accompanied by: Shortness of breath__Right leg pain__Left leg pain__

Other: ____.

7.) Since your previous visit in our office, have you had any of the following:

Knee Surgeries: Y__N__ If so, Right__ or Left__? When?____________________.

Back Surgeries: Y__N__ If so, What part of your back?______________When? ______________.

Hip Surgeries: Y__N__ If so, Right__ or Left__? When? ____________________.

Do you have trouble with any of the following activities?

Walking__ Explain: ____________________ Bathing__ Explain: ____________________

Dressing__ Explain:____________________ Housework__ Explain: ____________________

Standing for long periods__ Explain: ____________________ Walking up stairs__ Explain: ____________________ Driving__ Explain: ____________________

Is there any reason you would not be able to walk on a treadmill, if needed: Y___N___ If yes, please explain the reason: ____

8.) Do you smoke, dip or vape? Yes__ or No__. If yes, what do you smoke? _______ How many packs or cans do you use daily? ____________. How long have you been a smoker? ________________

Former smoker__. How long ago did you quit smoking? ____________________

Do you consume alcohol? Yes__ or No__. If yes, how many drinks do you consume per day? _______.

Do you or have you ever used illicit drugs? Yes__ or No__.
If yes, what drugs have you used? ________________________________. When is the last time you used? ________________.

9.) Family History: Is your Mother living or deceased? ____________, if deceased, age upon death____.

Is your Father living or deceased? ____________, **if deceased, age upon death**____.

Is there any family history of cardiovascular disease (Diabetes, High blood pressure, high cholesterol, Strokes, Heart attacks, Cardiac arrhythmias)? Yes__ or No__, If yes please explain:
____
____
____.

10.) Are you currently or have you been experiencing any other symptoms that you would like to discuss with Dr. Garoutte? Yes__ or No__. If yes, please specify: ____________________
____
____.