CARDIOVASCULAR CONSULTANTS, P.A.

Keith M. Lindgren, M.D., FACC
Dennis J. Donohue, M.D., FACC
Robert DiBianco, M.D., FACC, FACP, FAHA
Louis J. Larca, M.D., FACC
David M. Brill, M.D., FACC, FSCAI
James L. Cockrell, Jr., M.D., FACC
Laurence R. Kelley, M.D., FACC
Daniel J. Fernicola, M.D., FACC
Mark A. Turco, M.D., FACC, FSCAI
Sung W. Lee, M.D., FACC
Maureen Collins Fennell, M.D., FACC

Name_____ DOB: _____

Today's Date_____ Phone Numbers: Home: _____

Age_____ Gender: M F Work: _____

Height_____ Weight_____ Cell: _____

Primary Care Physician_____ Referral Required? Yes No ___Attached

Have you had a cardiac consultation with one of our physicians? Yes No
Do you plan of having a consultation with a cardiologist? Yes No

Have you had testing at Cardiovascular Consultants in the past? Yes No
If Yes, what type of test was performed: _____

Why are you having this test performed? _____

Please Check All That Apply

Chest pain or discomfort	Yes	No
Irregular heartbeat (Palpitations)	Yes	No
Shortness of breath	Yes	No
Dizziness or fainting	Yes	No
High blood pressure	Yes	No
Diabetes	Yes	No
High Cholesterol	Yes	No
Heart murmur	Yes	No
Previous heart surgery	Yes	No
Family history of heart disease	Yes	No
Previous heart attack	Yes	No
Do you have erectile dysfunction?	Yes	No
Do you smoke?	Yes	No
Packs per day _____ x _____ years		
Did you previously smoke?	Yes	No
Packs per day _____ x years		
When did you quit? _____		
Do you exercise?	Yes	No
_____ days per week x _____ minutes		

Please List All Your Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is there anything else you want us to know?

_____