FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Interventional Cardiology

Name _____ **Date of Birth** _____

Personal Health History	
Check if you have had any of the following	
☐ Cardiomyopathy (weak heart)	☐ Claudication (leg pain with walking)
☐ Coronary Artery Disease	☐ Peripheral Vascular Disease
☐ Myocardial Infarction (heart attack)	☐ Phlebitis
☐ Valvular Heart Disease	☐ Raynaud's
☐ Aortic Aneurysm	☐ Varicose Veins
☐ Carotid Disease	☐ Other:
☐ Deep Vein Thrombosis (DVT)	

Previous Cardiac Surgeries, Procedures, or Tests			
Procedure	Year	Procedure	Year
☐ Coronary Artery Bypass		☐ Cardiac Cath	
☐ ICD Placement		☐ Coronary Angioplasty/Stent	
☐ RF Ablation		☐ Cardioversion	
☐ Heart Valve Repair/Replaced		☐ EP Study	
☐ Aneurysm Repair		☐ Holter/Event Monitor	
☐ Nephrectomy (Kidney Removed)		☐ Stress test	
☐ Thyroidectomy		☐ Echocardiogram	
		☐ Other:	

Current Health Concerns	
Please check problems or conditions that you are CURRENTLY experiencing	
☐ Chest pain	☐ Swelling of feet, ankles or hands
☐ Shortness of Breath	☐ Fainting Spells
☐ with exertion	☐ Pain/cramps/numbness in legs
☐ at rest	☐ Other:
☐ awakening from sleep	
☐ sleeping propped up to breath easier	

Family History				
Please check all that apply				
	Father	Mother	Brother	Sister
Anemia				
Arrhythmia				
Clotting Disorder				
Heart Failure				
Sudden Death				
None of the above				

Patient/Guardian Signature: _____ Date: _____

Rev. 10/2021

Scanning Category: Administrative/Patient Forms