

Fainting	Yes	No	When:	_____
Near-Fainting	Yes	No	When:	_____
Cardiac Arrest	Yes	No	When:	_____
Shortness of Breath	Yes	No	When:	_____
Chest Discomfort	Yes	No	When:	_____
Leg Swelling	Yes	No	When:	_____
Congestive Heart Failure	Yes	No	When:	_____

HOSPITALIZATIONS

Reason for Hospitalization	Year	Hospital (City)
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? (Please check all that apply)

Cardiac/	Chest Pains or angina	<input type="checkbox"/>	Swelling of feet, ankles, hands	<input type="checkbox"/>
Vascular	Palpitations	<input type="checkbox"/>	Leg pain with walking	<input type="checkbox"/>
	Syncope (fainting)	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>
Constitutional	Recent Weight Change	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Respiratory	Chronic or Frequent Coughs	<input type="checkbox"/>	Spitting up Blood	<input type="checkbox"/>
	Shortness of Breath on Exertion	<input type="checkbox"/>	Shortness of Breath at rest	<input type="checkbox"/>
	Asthma or Wheezing	<input type="checkbox"/>	Snoring	<input type="checkbox"/>
Gastrointestinal	Loss of appetite	<input type="checkbox"/>	Nausea or Vomiting	<input type="checkbox"/>
	Blood in Stool	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>
Musculoskeletal	Joint Pain	<input type="checkbox"/>	Muscle weakness or pain	<input type="checkbox"/>
Skin/ Derm	Rash	<input type="checkbox"/>	Skin Sores	<input type="checkbox"/>
Neurological	Frequent Headaches	<input type="checkbox"/>	Lightheaded or Dizzy	<input type="checkbox"/>
	Seizures	<input type="checkbox"/>	Stroke or TIA	<input type="checkbox"/>
	Tremors	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>
Psychiatric	Nervousness or Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>
	Difficulty Sleeping	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>
Genitourinary	Blood in Urine	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>
	Painful or Burning Urination	<input type="checkbox"/>		
Hemetologic	Anemia	<input type="checkbox"/>	Bleeding or Bruising tendency	<input type="checkbox"/>
HEENT	Hearing Loss	<input type="checkbox"/>	Vision Changes	<input type="checkbox"/>

Signature of Patient

Date