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REFERRED SERVICES CARDIOPULMONARY INTAKE

Today's Date _____ **Date of Birth** _____ **Legal Gender** _____ **Gender Identity** _____

Name _____ **Referring Physician** _____

Reason for Referral _____

Have you (S) or a family member (F) had any of the following medical problems now or in the past?

S	F		S	F		S	F	
☐	☐	High blood pressure	☐	☐	Blood clots / DVT / PE	☐	☐	Bleeding problems
☐	☐	High cholesterol	☐	☐	Peripheral arterial/venous disease	☐	☐	Cancer
☐	☐	Diabetes	☐	☐	Arrhythmia / PVC / PAC	☐	☐	Abdominal aortic aneurysm
☐	☐	Heart attack	☐	☐	Abnormal EKG	☐	☐	Sleep apnea
☐	☐	Heart valve problems / murmur	☐	☐	Asthma	☐	☐	Hypothyroidism
☐	☐	Heart failure	☐	☐	COPD	☐	☐	Graves / Hyperthyroidism
☐	☐	Stroke	☐	☐	Easy bruising	☐	☐	Other: _____

Surgical History / Hospitalizations

Year	*Procedure / Reason for Hospitalization*

Allergies to medications, food, or environment ☐ **NONE**
Include reaction and age of onset if known

_____

_____

_____

Care Team

☐ Primary Care Provider: _____

☐ Cardiologist: _____

☐ Other: _____

_____

Prior Testing	Date		Date		Date
Resting 12-lead EKG		Angiogram		X-ray of:	
EKG stress test		CAC score		Peak flow testing	
Nuclear stress test		CT scan of:		Spirometry	
Echocardiogram		MRI of:		Other:	
Echo stress test		Ultrasound of:		Other:	
Holter monitor		Chest X-ray		Other:	

Do you have any of the following:
☐ Pacemaker ☐ Stent ☐ Defibrillator ☐ Other: _____

Smoking Status
☐ Never smoker ☐ Heavy smoker ☐ Packs/day: _____
☐ Former smoker ☐ Some day smoker ☐ How many years? _____
☐ Current every day smoker ☐ Light smoker ☐ Quit date: _____

Recreational Drug Use ☐ Current ☐ Past ☐ Prescription ☐ Cannabis only ☐ Other _____

How many days in the past year have you had an alcoholic beverage?
☐ Daily or almost daily ☐ Weekly ☐ Never
☐ Less than monthly ☐ Monthly

Exercise
What do you do for exercise? _____

How long? _____ How many days per week? _____

Nutrition
☐ Dairy free ☐ Gluten free ☐ Vegetarian ☐ Vegan ☐ Ketogenic ☐ Paleo ☐ Other _____

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Snacks _____

Beverages _____

Caffeine *Include type, how many, how often* _____

Prescription Medications
Use additional space as needed below or on the next page.

Name	Dosage *(Amount / Frequency)*	Prescriber	Start Date / Year if known

Non-Prescription Medications

☐ Aspirin ☐ Naproxen / Aleve ☐ Tylenol / Acetominophen ☐ Ibuprofen / Advil ☐ Other (list below)

Name	Dosage *(Amount / Frequency)*
☐ Allergy medication:	
☐ Cold or cough medication:	

Supplements / Vitamins

Include name, brand, dose, how many, how often, start date/year if known. Use additional space as needed below.

Name	Brand	Dosage *(Amount, Frequency)*	Start Date / Year if known