Please scan and email (or fax) the following pages to us
as soon as you can – well in advance of your visit!!
Email to Cardiac@LevinsonHarris.com Fax to 617 247 9444

Your Full Name
Marital status Married Sngl Sep Div Widow
You live ☐Alone ☐With:

Today's Date
Birth Date
MGH Unit #

Your contact info
Address
Phone ( ) --
Cell ( ) --
Fax ( ) --
Email

Spouse or significant other
Name
Phone ( ) --
Cell ( ) --
Email

Work (if retired, what did you do before?)
Company
Job & title
Phone
Retired? Yes / No when:

Emergency contact (not spouse)
Name
Relation
Phone ( ) --
Cell ( ) --
Email

Your primary physician
Name
Address
Phone ( ) --
Fax ( ) --

Other physicians involved in your care

	Name	Specialty	Phone
1			
2			
3			
4			
5			

Your pharmacy name
Location and Phone

Insurance Data	Name of insured	Insurance company	Policy Number
Primary insurance			
Secondary insurance			

Who referred you to us?

What is the main problem leading to this consultation?

Your personal medical history

Yes	No	???	
			Have you **ever** smoked cigarettes?
			High blood pressure
			Diabetes
			High or "bad" cholesterol
			Arterial disease / vascular surgery
			Varicose veins / vein stripping
			Rheumatic Fever
			Heart attack
			Use of Redux or Fen-Phen **ever**
			Heart Surgery / angioplasty

packs/day | # years smoked | Date Quit

/ /

Please write any comments below

			Dentures / partial plates
			Other Surgery
			Anything else? Write it in please

Disease which **run in your family** (your: parents, grandparents, siblings, aunts/uncles, children)

Yes	No	???	
			Heart attack/angina
			Atrial fibrillation
			Cardiomyopathy
			Sudden death
			Mitral prolapse
			Hypertension (high blood pressure)
			High cholesterol
			Aortic aneurysm
			Brain aneurysm
			Stroke
			Diabetes
			Breast cancer
			Colon or rectal cancer
			Ovarian or uterine cancer
			Prostate cancer
			Other cancers???

Medications you are **currently** taking

	Name of the medication	# mg in each tablet	# of pills taken at a time	# of times you take this in a day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Medication Allergies and intolerances

Allergy to X-Ray contrast dye? YES NO Never had it

Habits, activity, & misc

Alcohol - drinks per day	None Rare 1/day 2/day 3 or
Recreational Drug use	Neve other
Caffeine, cups per day	None Rare 1/day 2/day 3 or
Salt	No added salt low unrestricted
Fat	Very low low unrestricted
What exercise do you do	None Walking Cardio Resistance Other:
How many days per week	None 1 2 3 4 5 6 7
Weight now	
Weight at 20yo	
Height	
Waist & collar sizes	

Immunization history – Please write month and year for most recent immunizations

	MM/YY		MM/YY
Hepatitis A		Pneumovax (pneumonia)	
Hepatitis B		Flu shot	
Tetanus		Zoster (shingles)	

Your health maintenance history

	Most recent MM/YY	Where was it done?	Results?
Colonoscopy			
Mammogram			
Gynecology exam			
Bone density scan			
Abdom Aorta ultrasound			
Carotid ultrasound			

Please check any CURRENT SYMPTOMS you are having

❑ Fevers, chills, sweats	❑ Fainting	❑ Muscle or joint pains
❑ Weight loss	❑ Breast lump	❑ Rash
❑ Weight gain	❑ Nipple discharge	❑ Changing moles
❑ Excess thirst	❑ Cough	❑ Itching
❑ Excess hunger	❑ Wheezing	❑ Headache
❑ Change in vision	❑ Short of breath	❑ Dizzy
❑ Hearing loss	❑ Abdominal pain	❑ Memory loss
❑ Ringing in ears	❑ Blood in bowel movement	❑ Confusion
❑ Oral/dental trouble	❑ Nausea/vomiting	❑ Muscle weakness
❑ Hay fever	❑ Diarrhea/constipation	❑ Loss of coordination
❑ Allergies	❑ Other change in stool	❑ Anxiety / stress
❑ Chest pain	❑ Vaginal bleeding	❑ Depression
❑ Leg ache with exertion	❑ Leaking urine	❑ Trouble with sleep
❑ Palpitations	❑ Penile/vaginal discharge	❑ Easy bruising
❑ Lightheadedness	❑ Sexual problems	❑ Unexplained lumps

Please write any other comments below