

New Mexico Heart Institute
Revisit Intake Form
Today's Date ____/____/____

Name _____ DOB ____/____/____ Last 4 numbers of your SS _____

The reason for your visit today:

Risk Factors

Are you currently using tobacco?
Yes No
Type : (please circle) cigarettes, cigars,
pipe, chewing
Do you have high blood pressure?
Yes No
Do you have high cholesterol?
Yes No
Do you have diabetes? Yes No
Do you exercise? Yes No
Times per week _____
Minutes of exercise per session _____

For our female patients:

Are you menopausal? Yes No
Are you using hormone therapy?
Yes No

Allergies:

Review of Systems

Please answer the following questions if
you now have or have had since your last
visit:

Cardiac:

Chest pain or discomfort Yes No
Difficulty breathing (dyspnea)
Yes No
Awaking at night short of breath
Yes No
Using extra pillows or sleeping upright;
how many _____ Yes No
Swelling (soft tissue; edema)
Yes No
Palpitations Yes No
Dizziness Yes No
Fainting (syncope) Yes No
Leg pain with exercise (claudication)
Yes No
Feeling tired (fatigue) Yes No

Your primary care provider is:

General

Weight loss of 5 pounds or more in the
past 6 months Yes No
Weight gain of 5 pounds or more in the
past 6 months Yes No

HEENT:

Tooth pain Yes No
Painful gums Yes No

Pulmonary

Cough Yes No
Cough up blood Yes No
Wheezing Yes No

Gastrointestinal

Decrease in appetite Yes No
Abdominal Pain Yes No
Vomiting blood Yes No
Bloody or tarry stools Yes No

Genitourinary

Painful urination (dysuria) Yes No
Frequent urination Yes No
Unable to restrain urination
Yes No
Blood in the urine Yes No

Neurology

Limb weakness (arm or leg weakness)
Yes No
Sensory disturbances (change in touch,
smell, hearing, etc) Yes No

Hematology

Unusual bleeding Yes No
Problems bruising Yes No

Musculoskeletal

Muscle weakness Yes No
Muscle aches, generalized Yes No
Joint pain, localized Yes No

Skin

Rash Yes No
Itching Yes No

Psychiatric

Depression Yes No
Anxiety Yes No
Insomnia Yes No