

New Mexico Heart Institute  
Patient Intake Form  
Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

**Risk Factors**

Have you ever used tobacco? Yes  No   
Type : (please circle)  
cigarettes, cigars, pipe, chewing  
Currently using: Yes  No   
Amount: \_\_\_\_\_ # of years \_\_\_\_\_  
Year Quit: \_\_\_\_\_

Do you have high blood pressure?  
Yes  No   
If yes, how many years \_\_\_\_\_

Do you have high cholesterol?  
Yes  No  Don't know

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

**Cardiac Symptoms & History**

Do you have:  
Chest pressure or pain? Yes  No   
Dizziness? Yes  No   
Leg pain with walking? Yes  No   
TIA (Mini Strokes)? Yes  No   
Stroke? Yes  No   
Swelling of the feet or legs? Yes  No   
Shortness of breath? Yes  No   
Waking up at night short of breath?  
Yes  No   
Sleep on more than 2 pillows? Yes  No   
Palpitations? Yes  No   
Heart rhythm problems? Yes  No   
Loss of consciousness? Yes  No   
Heart murmur? Yes  No   
Abnormal EKG? Yes  No   
Enlarged Heart? Yes  No

**Family History**

Do your parents, brothers or sisters, or children  
have any of the following problems?

Heart disease or heart attack?  
Yes  No   
Men before the age of 50? OR  
Women before the age of 60?  
Yes  No

High blood pressure? Yes  No   
High cholesterol? Yes  No   
Diabetes? Yes  No   
Aortic Aneurysms? Yes  No   
Sudden death? Yes  No

**Personal History**

Marital Status:

Single \_\_\_\_  
Married \_\_\_\_  
Widowed \_\_\_\_  
Divorced \_\_\_\_

Who lives with you? \_\_\_\_\_

Employment:

Full time \_\_\_\_  
Part-time \_\_\_\_  
Retired \_\_\_\_  
Loss of job \_\_\_\_  
Disabled \_\_\_\_

Type of work \_\_\_\_\_

Number of cups of coffee a day \_\_\_\_\_

Number of cups of tea a day \_\_\_\_\_

Number of cola drinks a day \_\_\_\_\_

Do you use alcohol: Yes  No

If yes, how many \_\_\_\_ drinks per day  
OR how many \_\_\_\_ drinks per week  
OR how many \_\_\_\_ drinks per month

**List your medicines and supplements**

Name Dose Frequency

Pharmacy Name \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES** Yes  No  Please List

Medications \_\_\_\_\_

Dyes \_\_\_\_\_

Food \_\_\_\_\_

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**Review of Systems**

Please answer the following questions if you now have or ever had the following:

**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

Undue tiredness Yes  No

Loss of appetite Yes  No

**HEENT**

Headache Yes  No

Temporary loss of vision Yes  No

Double vision Yes  No

Hard of hearing Yes  No

Gum disease Yes  No

**Pulmonary**

Loud snoring Yes  No

Stop breathing while asleep Yes  No

Cough up blood Yes  No

Chronic cough Yes  No

Wheezing Yes  No

Cough up sputum(phlegm) Yes  No

**Gastrointestinal**

Heartburn Yes  No

Vomiting blood Yes  No

Bloody or tarry stools Yes  No

Jaundice Yes  No

**Genitourinary**

Painful urination Yes  No

Get up at night to urinate Yes  No

Blood in the urine Yes  No

**Musculoskeletal**

Chronic back pain Yes  No

**Hematology**

Unusual bleeding Yes  No

Problems bruising Yes  No

**Neurology**

Seizures Yes  No

Paralysis of any part of the body Yes  No

Loss of ability to speak clearly Yes  No

**Endocrine**

Increased thirst Yes  No

Frequent urination Yes  No

**Skin**

Rashes Yes  No

Ulcers/Wounds Yes  No

**Psychiatric**

Depression Yes  No

Anxiety Yes  No

Taken pills for depression Yes  No

Taken pills for anxiety Yes  No

Anger easily Yes  No

**Previous Surgeries** None

Type	Date

**Other Health Problems or Injuries**

Anemia Yes  No

Arthritis Yes  No

Asthma Yes  No

Bleeding problems Yes  No

Cancer Yes  No

COPD Yes  No

Emphysema Yes  No

Glaucoma Yes  No

Liver Problems Yes  No

Reflux Yes  No

Sleep Apnea Yes  No

Thyroid problems Yes  No

Ulcers Yes  No

**Men:**

Prostate problems Yes  No

**Women:**

Gynecologic problems Yes  No

Other: Please list

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