CENTINELA RADIOLOGY MEDICAL GROUP
Pre-Visit Form

Complete this form and bring it with you to your first doctor's visit.

Patient Information

Patient Name:	_______________________________
Today's Date:	__________
Referring Physician:	_______________________________
Family Physician:	_______________________________
Date of Birth:	__________
Age:	_____
Height:	___ ft ___ in
Gender:	☐ female ☐ male
Marital Status:	☐ single ☐ married ☐ widowed ☐ divorced
Number of Children:	_____

Personal Health History

What is the reason for this visit:

Have you ever had a heart problem?	☐ Yes ☐ No

If yes, please explain:

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Do you have or have you ever had any of the following?

Condition	Date
☐ Rheumatic fever	Date:
☐ Heart murmur	Date:
☐ Heart attack	Date:
☐ Chest pain/pressure	Date:
☐ Heart failure	Date:
☐ Rapid heart beat or irregular pulse	Date:
☐ Light-headedness	Date:
☐ Dizziness	Date:
☐ Fainting	Date:
☐ Swelling of the ankles	Date:
☐ Pain in calf muscles when walking	Date:
☐ Congestive heart failure	Date:
☐ Shortness of breath	Date:

Have you ever had any of the following heart studies?

☐ EKG	☐ Echocardiogram
☐ 24 Hour monitor	☐ Cardiac Catheterization
☐ Treadmill	☐ Chest x-ray

Have you ever had a reaction to the dye used in certain cardiac x-rays?

☐ Yes ☐ No ☐ I have never had this type of x-ray

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Do you have any allergies to medication?	☐ Yes ☐ No	
If yes, which medications:		
Do you currently smoke?	☐ Yes ☐ No	Pack per day: Number of years:
Have you ever smoked?	☐ Yes ☐ No	Date stoppped:
Do you have elevated cholesterol?	☐ Yes ☐ No	Last checked:
Do you have high blood pressure?	☐ Yes ☐ No	How many years:
Do you drink alcoholic beverages?	☐ Yes ☐ No	How much each day:
Are you generally stressed?	☐ Yes ☐ No	
Do you drink caffeine?	☐ Yes ☐ No	How much:
Do you excerise?	☐ Yes ☐ No	
Are you following a special diet?	☐ Yes ☐ No	

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Occupation: ________________________

Describe your job tasks:

Are you retired?	☐ Yes ☐ No Date
Are you disabled?	☐ Yes ☐ No Date

If yes, describe your disability:

Describe any surgeries you have had:

Surgery	Year
____________________	_______
____________________	_______
____________________	_______
____________________	_______

Please check any other health condition you have or have had in the past:

__ Scarlet fever	__ Anxiety	__ Emphysema
__ Ulcer	__ Anemia	__ Arthritis
__ Stomach Disorder	__ Bowel Disorder	__ Fatigue
__ Urinary problem	__ Rheumatic fever	__ Depression
__ Constipation	__ Menstrual dysfunction	__ Kidney disease
__ Breathing problems	__ Venereal disease	__ Sexual dysfunction
__ Asthma	__ Allergies	__ Hay Fever
__ Gout	__ Thyroid disease	__ Diabetes
__ High Blood Sugar	__ Migraine headache	__ Liver disease

__ Cancer (type: ______________________________)

__ Other: ______________________________

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Family History

Do you have a history of heart disease in your family? ☐ Yes ☐ No

If yes, indicate relation and age problems started:

Family Member(s)	Alive	Deceased	Current Age/ Age at Death	Cause of Death
Mother	☐	☐	_______	_______
Father	☐	☐	_______	_______
Sister(s)	☐	☐	_______	_______
	☐	☐	_______	_______
	☐	☐	_______	_______
Brother(s)	☐	☐	_______	_______
	☐	☐	_______	_______
	☐	☐	_______	_______