PARGOL SAMANI, M.D., INC.

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Patient Name: _______________________________

Heart Disease History		**If yes, please describe**
History of heart attack	☐ Yes	
History of angioplasty, stents or bypass surgery	☐ Yes	
History of valve replacement, TAVR	☐ Yes	
Pacemaker of defibrillator	☐ Yes	
Heart failure now or previously	☐ Yes	
High blood pressure	☐ Yes	
High cholesterol	☐ Yes	
Diabetes or borderline diabetes	☐ Yes	
Overweight/Obesity	☐ Yes	
Have you been told you have a “heart murmur”	☐ Yes	
Have you been told you have a “ leaky heart valve”	☐ Yes	
History of stroke or “mini-stroke” or TIA	☐ Yes	
History of blood clot (in legs or lungs)	☐ Yes	
History of atrial fibrillation or electric shock	☐ Yes	
History of irregular heartbeats or arrhythmia	☐ Yes	
Aneurysm/enlargement of aorta	☐ Yes	
Kidney disease	☐ Yes	
Have you ever had any cardiovascular work up in the past (like ultrasound of the heart or stress test or heart monitor)	☐ Yes	

Symptoms		**If yes, please describe**
Chest pain, tightness or pressure or discomfort	☐ Yes	
Jaw, arm, or shoulder pain	☐ Yes	
Shortness of breath at rest	☐ Yes	
Shortness of breath with walking, going upstairs	☐ Yes	
Waking up with shortness of breath at night	☐ Yes	
Palpitation or rapid heartbeats	☐ Yes	
Skipped heart beats	☐ Yes	
Irregular heartbeats, fluttering	☐ Yes	
Slow heart rate, Heart stopping	☐ Yes	
Dizziness or lightheadedness	☐ Yes	
Near fainting or fainting or syncope now or in the past	☐ Yes	
Fatigue	☐ Yes	
Calf pain or cramps at rest or with walking	☐ Yes	
Buttock or tight pain with walking	☐ Yes	
Swelling (puffiness) in the legs or feet or ankles	☐ Yes	
Weakness or numbness or paralysis	☐ Yes	
Vision change, double or blurry vision	☐ Yes	
Difficulty finding words or slurry speech or confusion	☐ Yes	
Difficulty with balance	☐ Yes	
Unusual weight loss of weight gain	☐ Yes	
Fever, chills or night sweats	☐ Yes	
Snoring	☐ Yes	
Feeling tired and not fully rested in the morning	☐ Yes	

Medications	**Dose (mg)**	**How Often (once a day, etc…)**
1-		
2-		
3-		
4-		
5-		
6-		
7-		
8-		

Allergies to Medication or Food	☐ Yes	**If yes, please describe**
Penicillin	☐ Yes	
Shell Fish	☐ Yes	
Other	☐ Yes	

Prior Medical Condition or Surgery	☐ Yes	**If yes, please describe**
1-		
2-		
3-		
4-		

Health and Fitness		**If yes, please describe**
Do you smoke or vape or use any nicotine related products?	☐ Yes	If yes, how much?
Did you smoke in the past?	☐ Yes	What type and how much?
Do you exercise?	☐ Yes	What type and how much?
Do you drink alcoholic beverages?	☐ Yes	What type and how much per day?
Do you drink caffeinated beverages?	☐ Yes	How much per day?
Do you work?	☐ Yes	Do you do physical work?
Do you eat healthy?	☐ Yes	What are the weaknesses in your diet?

Family Histories		**If yes, please describe**
Any family member with heart issue in your family?	☐ Yes	
Any family member with heart attack before age 65?	☐ Yes	
Any family member with sudden cardiac death?	☐ Yes	
Any family member with high blood pressure?	☐ Yes	
Any family member with high cholesterol?	☐ Yes	
Any family member with diabetes?	☐ Yes	
Any family member with arrhythmia or atrial fibrillation	☐ Yes	
Any family member with enlarged aorta?	☐ Yes	

What are the heart and/or blood circulation related concerns that you would like to discuss with the doctor?