CENTERS FOR
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Cardiac Intake Form

Select the appropriate option and/or provide an answer to each of the items below:

OVERVIEW OF HISTORY	
Patient's Name & Current Date	
Patient is from (city, state, country)	
Patient's Age & DOB	_____ Age _____ Birthdate
Patient Marital Status	☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partner
Patient's Gender	☐ Male ☐ Female ☐ Intersex / Hermaphrodite ☐ Transgender
Patient's Ethnicity	☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Hispanic ☐ Hawaiian/Pacific Islander ☐ Other (please specify)
How did you hear about our clinic?	
What is your current Primary Diagnoses?	
HISTORY OF PRESENT ILLNESS	
Date symptoms began (onset of actual symptoms)	
WHAT was the first evidence of the problem?	
WHEN was first evidence of the problem beginning?	
Date diagnosed	
How was diagnosis made?	☐ EKG (Electrocardiogram) ☐ Stress Test ☐ Echocardiography ☐ Cardiac Catheterization ☐ Chest X Ray ☐ Blood Tests ☐ Coronary Angiography ☐ Other (please specify)
Who made the diagnosis?	
INITIAL SYMPTOMS BEFORE DIAGNOSIS	
Constitutional symptoms prior to diagnosis	☐ Weight change ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Appetite change ☐ Fever ☐ Chills ☐ Night sweats ☐ Pain ☐ Fatigue ☐ Exhaustion ☐ Shortness of breath ☐ Difficulty breathing ☐ Chest pain ☐ Weakness ☐ Have to sit up to breath (orthopnea) ☐ Pain when breathing (dyspnea) ☐ Radiating pain in jaw or arms ☐ Other (please specify)
Weight when initial symptoms began	_____ lbs ☐ Eating Healthy ☐ Exercising ☐ Dieting
Appetite when initial symptoms began	☐ Excellent ☐ Good ☐ Poor ☐ No Appetite
SYMPTOMS AT TIME OF DIAGNOSIS	
Constitutional symptoms at time of diagnosis	☐ Weight change ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Appetite change ☐ Fever ☐ Chills ☐ Night sweats ☐ Pain ☐ Fatigue ☐ Exhaustion ☐ Shortness of breath ☐ Difficulty breathing ☐ Chest pain ☐ Weakness ☐ Have to sit up to breath (orthopnea) ☐ Pain when breathing (dyspnea) ☐ Radiating pain in jaw or arms ☐ Other (please specify)
Weight at time of diagnosis (lbs)	_____ lbs ☐ Eating Healthier ☐ Increased Exercise ☐ Continued Dieting
Appetite at time of diagnosis	☐ Excellent ☐ Good ☐ Poor ☐ No Appetite
CURRENT SYMPTOMS AS OF TODAY	

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Select the appropriate option and/or provide an answer to each of the items below:	
Constitutional symptoms as of today	☐ Weight change ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Appetite change ☐ Fever ☐ Chills ☐ Night sweats ☐ Pain ☐ Fatigue ☐ Exhaustion ☐ Shortness of breath ☐ Difficulty breathing ☐ Chest pain ☐ Weakness ☐ Have to sit up to breath (orthopnea) ☐ Pain when breathing (dyspnea) ☐ Radiating pain in jaw or arms ☐ Other (please specify)
Current weight (lbs)	_____ lbs ☐ Eating Healthier ☐ Increased Exercise ☐ Continued Dieting
Current appetite	☐ Excellent ☐ Good ☐ Poor ☐ No Appetite
HISTORY OF TREATMENTS RELATED TO DIAGNOSIS	
Surgeries history related to diagnosis (dates and type)	
Condition after treatment regimen or surgery	
CURRENT SITUATION	
Primary problem today?	
When did primary problem start?	
Where is primary problem located?	
When is problem worse, and for how long?	
How often does problem occur?	
When is the problem better?	
What has been done to help problem?	
What treatments have been successful in helping the problem?	
Experiencing any pain? Where?	
Complications since diagnosis	
Medications currently being taken and purpose	

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Select the appropriate option and/or provide an answer to each of the items below:	
Any other information regarding your diagnosis you feel is pertinent for the provider to know?	
EXPOSURE HISTORY	
History and recent use of Tobacco (how much, how long, dates used)	
History and recent use of Alcohol (type used, how much, how long, dates used)	
History and recent use of Illicit Drug (type used, how much, how long, dates used)	
Chemical Exposure History (type, how much, how long, dates) Examples: Pesticides, Fuel, Fertilizers, Insecticides	
Metals Exposure History (type, how much, how long, dates) Examples: Lead, Aluminum, Mercury, Copper, Steel	
Any amalgams (mercury fillings) removed?	☐ Yes ☐ No If yes, how many? _____
How many amalgams does patient currently have?	
Does patient have a high seafood diet?	
What vaccines has the patient had? (Give general information)	
How many antibiotics has patient taken in the past year?	
Context (check all that apply)	☐ pain at rest ☐ pain during physical exertion ☐ increased belching/burping ☐ pain while walking after eating ☐ postural change ☐ pain after eating
Associated Symptoms (check all that apply)	☐ numbness ☐ palpitations ☐ orthopnea ☐ tingling ☐ dyspnea ☐ diaphoresis ☐ heartburn ☐ belching ☐ sexual dysfunction ☐ sweating
Cardiac Risk Factors (check all that apply)	☐ thickened toenails ☐ less hair on toes or fingers ☐ thickened skin on feet ☐ cold hands & feet ☐ purple color to toes or feet
Quality of symptoms (check all that apply)	☐ acute ☐ constant ☐ crushing ☐ dull ☐ pressure ☐ tightness
MEDICAL HISTORY	
Do you have any other medical conditions?	

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Select the appropriate option and/or provide an answer to each of the items below:	
Have you had any other surgeries?	
Any other treatment history?	
How many times have the patient been pregnant, at what age was the pregnancy, and did the pregnancy result in a live birth?	
Any other medical history that you feel is pertinent for the provider to know?	
FAMILY HISTORY	
Family History - Mother	☐ Heart issues/disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Unknown ☐ Other (please specify)
Family History - Father	☐ Heart issues/disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Unknown ☐ Other (please specify)
Family History - Siblings	☐ Heart issues/disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Unknown ☐ Other (please specify)
Additional Family History (if any)	
REVIEW OF SYMPTOMS	
Average number bowel movements daily	
Experienced in last 3 mo - Constitutional	☐ Fever ☐ Chills ☐ Sweats ☐ Tired ☐ Weight loss
Experienced in last 3 mo - Head	☐ Ear Pain ☐ Mouth Pain ☐ Tooth Pain ☐ Throat Pain ☐ Poor Hearing ☐ Nose Discharge
Experienced in last 3 mo- Neuro	☐ Headache ☐ Numbness ☐ Tingling ☐ Poor Balance / Coordination ☐ Urinary / Bowel
Experienced in last 3 mo - Eye	☐ Blurred Vision ☐ Double Vision ☐ Eye Pain
Experienced in last 3 mo – Muscular/Skeletal	☐ Muscle Pain ☐ Joint Pain
Experienced in last 3 mo - Skin	☐ Rash ☐ Itching ☐ Bites ☐ Sores ☐ Redness
Experienced in last 3 mo - G.I.	☐ Belly Pain ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Constipation
Experienced in last 3 mo - Respiratory	☐ Shortness of Breath ☐ Cough ☐ Pain ☐ Wheeze ☐ Snoring
Experienced in last 3 mo - Genito/Uri	☐ Painful / Frequent Urination ☐ Waking to Urinate ☐ Periods (F) ☐ Irregular Periods (F) ☐ Itching ☐ Pain ☐ Discharge (F)
Experienced in last 3 mo - Cardio	☐ Chest Pain / Pressure ☐ Light Headed ☐ Fluttering in Chest ☐ Swelling of Legs ☐ Fainting ☐ Palpation
Experienced in last 3 mo - Endocrine	☐ Often Cold ☐ Often Hot ☐ Over Tired ☐ Over Thirsty
Experienced in last 3 mo - Psych	☐ Depression / Feeling Blue ☐ Anxious ☐ Trouble Sleeping
Experienced in last 3 mo - Allergy	☐ Itchy Eyes ☐ Sinus ☐ Sneezing ☐ Frequent Infection

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Initial Intake Synopsis

If you feel all your pertinent medical history may need further explanation or you think the provider should be aware of any additional information, please provide us with a synopsis of this information in chronological order (i.e. health timeline, diagnoses, treatments undergone, type of practitioners seen, and etc.) See "Initial Intake Synopsis Example" on next page as reference.

Date: _____ Patient Name: _____