SCOTTSDALE CARDIOVASCULAR CENTER PC QUICK CARD

TODAY'S VISIT

Your Name: _____ **Physician:**_____

The reason for your visit today?_____

Since your last visit with us, have you experienced any of the following? (circle applicable)

Chest pain	Chest pressure	Chest tightness	
Abnormal sweating	Clamminess	Waking at night with shortness of breath	
Shortness of breath when laying down	Racing heartbeats	Skipped heart beats	
Feeling as if you are going to faint	Fainting episode	Cardiac arrest	
Pain or burning in legs when walking	Leg swelling	Leg coldness or discoloration	
Weight gain	Weight loss	Fever	
Visual Changes	Hearing loss	Snoring	
Coughing up blood	Short of breath	Nausea	
Reflux	Bleeding gums	Blood in urine	
Urinating during night	Dizziness	Memory loss	Seizures
Depression	Headaches	Anemia	Easy bruising of the skin

Have you been hospitalized since your last visit? YES NO

Approximate Dates: _____

Where?_____

Diagnosis:_____

Have you had lab work performed since your last visit? YES NO

Approximate Date:_____

Where?_____

Diagnosis:_____

Have you had any cardiac tests performed since your last visit? YES NO

Approximate Date:_____

Where?_____

Diagnosis:_____

*Your Signature:*_____