GAYLE MARTIN, M.D.
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	DO YOU HAVE OR HAVE YOU HAD	YES	NO	DATE(M/Y)
A	Chest pain?			
B	Shortness of breath?			
C	Palpitation or heart fluttering or rhythm problems?			
D	Swelling in your legs?			
E	To elevate your head in order to breath well?			
F	To get up at night to urinate?			
G	To sit up at night to get your breath?			
H	A Heart Murmur?			
I	A Heart Attack?			
J	Anyone in your family with Heart trouble?			
K	Diabetes Mellitus			
L	High Cholesterol?			
M	Rheumatic Fever?			
N	Have you ever been treated for High Blood Pressure?			
O	A history of Thyroid problems?			
P	A history of Kidney Disease?			
Q	Episodes of loss of Consciousness?			
R	Told you have Congestive Heart Failure?			

	HAVE YOU EVER HAD	YES	NO	DATE(M/Y)
A	Tuberculosis			
B	Pneumonia			
C	Syphilis			
D	Cancer			
E	Stress Test			
F	Pacemaker placement or Defibrillator placement			
G	Echocardiogram			
H	Stent placement or Balloon Angioplasty			
I	Cardiac Catherization			
J	Heart Valve Surgery			
K	Coronary Artery Bypass Grafting Surgery			

	DO YOU HAVE	YES	NO	DATE(M/Y)
A	Severe or frequent headaches?			
B	Problems with you vision?			
C	Nose bleeds?			
D	Decreased hearing?			
E	Ringing in your ears?			
F	Difficulty swallowing?			
G	Stomach pain, Ulcers, indigestion? Circle all that applies			
H	Change in bowel habits?			
I	Black or Tarry looking stool?			

HAVE YOU HAD	YES	NO	DATE(M/Y)
A recent or Chronic Cough? Circle all that applies			
Episodes of Cough up blood?			

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Episodes of Wheezing?			
Asthma?			
Emphysema?			
Difficulty or Pain Urinating?			
Blood in your urine?			
Episodes of frequent urination?			
Weakness in arm and legs?			
Seizures?			
Passing out spells?			
Dizzy spells? Stroke? Circle all that applies			

DO YOU OR HAVE YOU HAD ALLERGIES TO ANY MEDICATION:	***Yes***	***No***	***Please List***
HAVE YOU HAD ANY SURGERY*:*	***Yes***	***No***	***Please List***
DO YOU SMOKE CIGARETTES AND OR CIGARS? …	***Yes***	***No***	***If Yes***
Number per day _____ / or _____ Number of years			
Formerly smoke?	***Yes***	***No***	***Year you Quit***
DO YOU DRINK ALCOHOL	***Yes***	***No***	
Daily?	***Yes***	***No***	***If Yes drinks per day***
Socially?	***Yes***	***No***	
DO YOU EXERCISE ON A REGULAR BASIS…	***Yes***	***No***	***If Yes please specify***

FAMILY HISTORY: LIVING/DECEASED AGE & CAUSE OF DEATH

CHECK ONE	**Living / Deceased**		
Mother			
Father			
Sisters (how many)			
Brothers (how many)			

FOR MEN ONLY:	***Yes***	***No***	
Do you have Erectile Dysfunction?			

FOR WOMEN ONLY: :	***Yes***	***No***	
Do you have a menstrual cycle?			
How many pregnancies?			
How many miscarriages?			
Do you have Toxemia?			
Do you have Hypertension?			
Do you have Diabetes Mellitus?			

PRESENT MEDICATIONS	**mg**	**x-day**	**How Long**
1.			
2.			
3.			
4.			