



InteCardia

A Prevention Service of
Virginia Cardiovascular Specialists

Patient Registration

Test Date ___ / ___ / ___

Patient Name _____
Last First Middle Suffix

Sex Male Female

Birth Date ___ / ___ / ___

Age _____

Emergency Contact

Name _____

SSN _____

Relation _____

Address _____

Phone _____

Zip Code _____

Employment

Employer Name _____

City _____ State _____

Phone _____

Home Phone _____

Occupation _____

Work Phone _____

Ethnicity _____

Mobile Phone _____

VCS Physician _____

E-mail _____

Referring Physician _____

Weight _____ lbs Height _____ ft _____ in

Women only: Pregnant? Yes No

Post Menopausal? Yes No

Cholesterol _____ LDL _____ HDL _____ Triglycerides _____ Total Cholesterol

Currently taking Cholesterol medication? Yes No If yes, name _____

Please check all that apply:

- chest pain
- chest tightness or pressure
- shortness of breath
- palpitations
- leg pain when walking
- slurring of speech
- fainting

Patient Health History:

Cancer Yes No If yes, type _____

High blood pressure Yes No If yes, medication _____

Daily aspirin Yes No If yes, adult aspirin baby aspirin

Current smoker Yes No Past smoker? Quit _____ years ago

Exercise frequency _____ day/week Exercise duration _____ minutes

Diabetes Yes No If yes, Insulin Oral Medications Diet

Cardiac History	Yes	No		Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Valve surgery
	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Heart bypass surgery
	<input type="checkbox"/>	<input type="checkbox"/>	TIA	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty/stents

Vascular Surgery Carotid Aorta Leg

Continued on back

