MCVS
MARYLAND
CARDIOVASCULAR
SPECIALISTS

Patient Follow Up Visit

Name:_____ Primary Care Physician:_____

Date of Birth: ___/___/___ Home Phone: (____) _____ Cell Phone: (____) _____

Since your last visit: Have you had any of the following? (Please circle and describe):

Yes No Have you been hospitalized? If yes, why? _____
_____
Yes No Chest discomfort or pressure with exertion?_____
Yes No Shortness of breath? _____
Yes No Waking at night short of breath? _____
Yes No Wheezing or cough? _____
Yes No Fever, chills, night sweats _____
Yes No Recent weight loss? How much? _____
Yes No Recent weight gain? How much? _____
Yes No Leg swelling? _____
Yes No Weakness or fatigue? _____
Yes No Palpitations or irregular heartbeats? _____
Yes No Light headedness or dizziness? _____
Yes No Blackouts? _____
Yes No Do you experience pain, aching, or cramps in your legs (calves or buttocks) when walking?_____
Which leg? Left ____ Right ____ How far can you walk (in blocks) before it starts? _____
Yes No Bruising or bleeding? Blood in you urine or stool? _____
Yes No Changes in bowel habits or abdominal pain? _____
Yes No Problems with urination? _____
How many times do you wake up to go to the bathroom at night? _____
Yes No Problems with sexual function? _____
Yes No Any STROKE symptoms or neurologic problems? _____
(Weakness? Numbness? Loss of sensation? Speech Problems?)
Yes No Memory problems or changes in behavior? _____
Yes No Depression or psychiatric condition? _____
Yes No Are you smoking? _____
Yes No Are you exercising? Doing what? _____
_____
Yes No Have you had a change in occupational status? _____

Any new symptoms or new problems since your last visit? _____
_____

When was your last cholesterol testing? _____ Where? _____

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Medications

Please list all of the medications that you are currently taking (name/dose/frequency)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name any drugs to which you are allergic and describe your reaction:

Have you ever had an allergic reaction to x-ray contrast dye, iodine, or shellfish? If yes, please describe your reaction.

Is there any other important information that you wish to share with your cardiologist?

_____
_____
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_____

Reviewed by: _____ Date: _____
Physician Signature