CoreCardiology
DIAGNOSTICS & TREATMENT CENTRE

Oakville Health Centre
215-1060 Speers Road, Oakville, ON, L6L 2X4
Office 905-842-6084 | **Fax** 905-842-4579
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Name: ______________________________ **Age:** ______ **Date:** ________________________________

Weight (kg): _________ **Height (metres):** _______________ **BMI =** ___________ (we will calculate)

Cardiac Risk Factors (please **CIRCLE** or **FILL** all that apply)

Do you smoke? Never/Yes/Ex-smoker (quit in ________), # ________ packs/day, #________ years

How many alcoholic drinks (1 beer = 1 wine = 1 shot) do you consumer per week? ________ /week

Do you use any recreational street drugs? Yes/No

Do you have diabetes? Yes/No

Do you have high cholesterol? Yes/No (say yes if being treated)

Do you have high blood pressure? Yes/No (say yes if being treated)

Do you have any relatives with heart disease? Yes/No

If so, who and at what age?

1.

2.

3.

4.

Within the past year, have you experienced any of the following?:

Chest Pain: Yes/No

Shortness of Breath: Yes/No

Palpitations (heart fluttering/pounding): Yes/No

Dizziness: Yes/No

Fainting: Yes/No

Gasping for air at night? Yes/No

Medical History (Please **CIRCLE** all that apply)

Have you ever had a heart attack? Yes/No

Have you ever been diagnosed with angina? Yes/No

Have you ever had a: STRESS TEST/ANGIOGRAM/CATHETERIZATION/HEART SURGERY?

Do you have a history of any of the following conditions (please CIRCLE all that apply):

CANCER/STROKE/BLOOD CLOTS

RHEUMATIC FEVER/SLEEP APNEA/EMPHYSEMA/CHRONIC BRONCHITIS/ASTHMA

STOMACH ULCERS/BLEEDING DISORDERS/ANEURYSMS

RHEUMATOID ARTHRITIS/FIBROMYALGIA/REFLUX DISEASE

ANEMIA/THYROID DISEASE

Current Medications:

Name of Medication	Dose (mg)	How many times daily?

Please list any medication allergies (these cause airway closure, hives, or rash):