PEDRO R. HERNANDEZ-LATTUF, M.D., P.A.
CARDIOLOGY

Name:_____

Date:_____

Family Physician:_____

HEALTH INFORMATION UPDATE SINCE YOUR LAST VISIT:

GENERAL:
Do you have prolonged fever?
Do you have recent weight loss?
Do you feel tired in the mornings?

SKIN:
Do you have skin problems?

VISION:
Do you have decreased vision?

EAR/NOSE/THROAT:
Do you have decreased hearing?
Do you have sinus trouble?
Do you have sore throats?

RESPIRATORY:
Do you cough?
Do you wheeze?
Do you have bloody sputum?
Do you snore?
Do you quit breathing at night?

CARDIOVASCULAR:
Do you have pain or discomfort in the jaw, neck, lower teeth, chest or arms during exercise, emotional upset, or at rest?
Does exercising, walking or climbing stairs make you short of breath?
Do you elevate your head with more than one pillow in order to breathe easier at night?
Have you been awakened from sleep with breathlessness or cough?
Do you have skipped beats?
Do you have rapid or slow heartbeats?
Do you have swelling of feet or ankles?
Do you have pain or tightness in your feet, calves, thighs, or buttocks while walking?
Do you have painful whitening of your fingertips when you are cold?

GASTROINTESTINAL:
Do you have frequent indigestion and/or abdominal pain?
Do you have nausea or vomiting?
Do you have bloody vomit?
Do you have black tarry or bloody stools?
Do you have recent appetite loss?

GENITOURINARY:
Do you have dark or bloody urine?
Do you have frequent urination at night?

OSTEOMUSCULAR:
Do you have leg cramps at night?
Do you have joint pain?
Do you have stiffness?

NEUROLOGICAL:
Do you develop numbness around the lips and in the fingers when you are short of breath?
Do you have fainting spells?
Have you had severe recurring headaches?
Have you had trouble with your coordination?
Have you had seizures?
Have you had paralysis?
Have you had trouble talking?
Have you had vertigo or dizziness?
Do you have trouble sleeping?

SOCIAL HABITS:
Do you use any form of nicotine product?
Do you drink alcohol?
Do you use recreational drugs?
Do you drink coffee, tea, or caffeinated beverages?
Do you follow a specific diet? LOW FAT LOW SALT?
Do you have a regular exercise program?

MEDICATION ALLERGIES: