TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Section I. **Patient** information

1. Last name(s): | 2. First name: | 3. Middle initial:

4. Date of birth: M M / D D / Y Y Y Y

5. Gender: ◯ Male ◯ Female

6. Height: ◯ Meters ◯ Feet

7. Weight: ◯ Kilos ◯ Pounds

8. Smoker?: ◯ Yes ◯ No

9. Cigarettes per day:

10. Since when?: Y Y Y Y

11. Until when?: Y Y Y Y

12. Lifestyle: ◯ Sedentary ◯ Semi-active ◯ Active

13. Latest records of blood pressure:

Date:	Blood pressure:	Date:	Blood pressure:	Date:	Blood pressure:
M M / Y Y Y Y	/ mm Hg	M M / Y Y Y Y	/ mm Hg	M M / Y Y Y Y	/ mm Hg

Section II. **Symptoms and/or signs** of the illness

1. Dizziness ◯ Yes ◯ No	2. Flushed facies ◯ Yes ◯ No	3. Headaches ◯ Yes ◯ No
4. Epistaxis ◯ Yes ◯ No	5. Nervousness ◯ Yes ◯ No	6. Vision disorders ◯ Yes ◯ No
7. Edema ◯ Yes ◯ No	8. Chest pain ◯ Yes ◯ No	9. Shortness of breath ◯ Yes ◯ No
10. Tachycardia ◯ Yes ◯ No	11. Arrhythmias ◯ Yes ◯ No	12. Exercise intolerance ◯ Yes ◯ No

13. Please explain the affirmative answers:

Section III. **Has the patient had or currently has** any of the following diseases?

1. Coronary heart disease ◯ Yes ◯ No	2. Cerebrovascular diseases ◯ Yes ◯ No	3. Peripheral artery disease ◯ Yes ◯ No
4. Hypertension ◯ Yes ◯ No	5. Rheumatic heart disease ◯ Yes ◯ No	6. Endocarditis ◯ Yes ◯ No
7. Congenital heart disease ◯ Yes ◯ No	8. Myocarditis ◯ Yes ◯ No	9. Deep vein thrombosis ◯ Yes ◯ No
10. Pulmonary embolism ◯ Yes ◯ No	11. Heart failure ◯ Yes ◯ No	12. Metabolic syndrome ◯ Yes ◯ No
13. Varicose veins ◯ Yes ◯ No		

14. Date of diagnosis: M M / Y Y Y Y

15. Please explain the affirmative answers:

Section IV. **Treatment**

1. Dietary control ◯ Yes ◯ No	2. Lifestyle changes ◯ Yes ◯ No	3. Medication ◯ Yes ◯ No
4. Angioplasty ◯ Yes ◯ No	5. Cardiovascular surgery ◯ Yes ◯ No	6. Other ◯ Yes ◯ No

7. Please explain the affirmative answers:

Section V. **Hospital** admissions

1. Has the patient ever been hospitalized? ◯ Yes ◯ No

2. Date: M M / D D / Y Y Y Y

3. Diagnosis:

Section VI. **Has the patient had any** of the following complications?

1. Renal failure ◯ Yes ◯ No
2. Retinopathy ◯ Yes ◯ No
3. Myocardial infarction ◯ Yes ◯ No
4. Hemiplegia ◯ Yes ◯ No
5. Peripheral vascular disease ◯ Yes ◯ No
6. Thrombosis ◯ Yes ◯ No

7. Please specify dates and explain the affirmative answers:

8. Additional information that you can provide regarding risk factors, illnesses or consultations with other doctors or specialists:

Section VII. **Results of tests** performed in the last 6 months

1. Date: M M / D D / Y Y Y Y
2. Total cholesterol:
3. HDL:
4. LDL:
5. Triglycerides:
6. Creatinine:
7. Glucose:

8. Other complementary studies:

Section VIII. **Results of tests** performed in the last 12 months

1. Date: M M / D D / Y Y Y Y
2. Electrocardiogram:
3. Date: M M / D D / Y Y Y Y
4. Exercise EKG:
5. Other complementary studies:

Section IX. **Attending physician's** information

1. Last name(s):
2. First name:
3. Middle initial:
4. Address:
5. Email address:
6. Office phone: + - -
7. Cellular phone: + - -
8. Signature and seal of the professional:
9. Date: M M / D D / Y Y Y Y

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