UCLA Cardiovascular Genetics Clinic
Ahman Cardiomyopathy Center
Division of Cardiology

Today's Date: ___ /___ /____
First name/Middle initial/Last name:_____
Date of Birth: ___ /___ /____ Gender: ☐ M ☐ F
Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other:_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
With whom do you live? _____
Phone Number: ( )_____
Occupation:_____
If retired or disabled enter your last occupation
Retired? ☐ No ☐ Yes: Date of retirement:_____
Disability ? ☐ No ☐ Yes :Date of disability:_____

Highest Level of Education:_____

Primary care doctor:
Name:_____ Phone: _____ Fax:_____
Address: _____

What would you like to address during your visit?

_____

_____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No
If yes, list the medication(s) and reaction:
_____
Do you smoke? ☐ No ☐ Yes How many packs per day ? _____
If you quit, when did you stop?: _____ How many years did you smoke? _____
Do you drink alcohol? ☐ No ☐ Yes How often? _____

DO YOU HAVE ANY OF THESE SYMPTOMS?

☐ Weight Loss
☐ Passing out episodes
☐ Headaches
☐ Palpitations or rapid beating heart
☐ Changes in bowl habits
☐ Seizures
☐ Shortness of breath at rest
☐ Nausea/vomiting/ diarrhea
☐ Temporary blindness in eye
☐ Unusual shortness of breath on exertion
☐ Vomiting blood or blood in bowel movement
☐ Numbness in arm or leg
☐ Difficulty breathing at night
☐ Painful urination
☐ Leg pain/fatigue with walking
☐ Chronic cough
☐ Excessive bleeding or Easy bruising
☐ Chest pain or pressure at rest
☐ Chest pain or pressure exertion
☐ Anxiety

During your pregnancies were you diagnosed with new high blood pressure/preeclampsia or diabetes? ☐ No ☐ Yes ☐ N/A

Please answer the following two questions about your recent mood:

1. In the past month have you often been bothered by feeling down, depressed, or hopeless?
☐ Yes ☐ No

2. During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Have you Ever Been Treated for any of the following (check as many as applicable):

☐ History of poor circulation
☐ High blood pressure
☐ Breathing problems like asthma or emphysema
☐ Stroke
☐ Heart murmur
☐ Anxiety
☐ Diabetes
☐ High cholesterol
☐ Angina or chest discomfort
☐ Heart attack
☐ Thyroid problems
☐ Rheumatoid disorder
☐ Stomach problems or ulcers
☐ Hepatitis
☐ Operations
☐ Anemia or low blood count
☐ Kidney problem

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

_____
_____
_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS:

Date	**Reason**

Medications

Name	**Dosage**	**How often?**