



Name _____ Date of Birth _____

Do you have any of the following conditions?

High Blood Pressure _____ High Cholesterol _____ Diabetes _____

Coronary Artery Disease _____ Peripheral Vascular Disease _____

Have you ever had any of the following?

Nuclear Stress Test _____ Echo (heart ultrasound) _____

Angioplasty _____ Heart Cath _____

Open Heart Surgery _____ Stroke _____

Hiatal Hernia _____ Ulcer _____

Please list any past surgeries performed:

How far can you walk?

Feet _____ Blocks _____ Miles _____ Unlimited _____

What limits your ability to walk further? _____

Have you ever smoked? _____ Do you smoke now? _____

Do you drink alcohol? _____

Any other medical problems:

Have you recently been in the hospital or ER? Yes / No

If so which hospital were you seen? _____

Approximate date you were seen: _____