Date: ___________________

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_____________

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? ___________

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: ____