ZILKHA RADIOLOGY

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Patient Medical History for Echocardiogram

Date _____ **Chart #:** _____

Patient Name: _____ **Date of Birth:** _____

Please check the box if you currently have…

Chest Tightness or Pain		Fever	
Shortness of Breath		Edema	
Wheezing		Lyme's Disease	
Palpitations		Sarcoidosis	
Sleep Apnea or Insomnia		Iron Metabolism Disorder	
Heart Murmur		Angina	
Coronary Artery Disease		Lupus	
Atrial Fibrillation/ Flutter		History of Stroke	
Mitral/ Aortic Valve Disorder		History of Heart Attack	
Congestive Heart Failure		High Blood Pressure	

If **NO** to all questions above, what symptom(s)/ medical issue(s) has brought you into us? _____

_____

_____

Surgical History:

Heart Valve Replacement **YES** **NO**

Coronary Bypass Surgery **YES** **NO**

Other Coronary Surgery **YES** **NO**

Explain: _____

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature _____ **Date**_____