

**Advanced Heart Care, LLC**

**Dr. Omar Almousalli M.D.**

**4600 Memorial Dr. W3**

**Belleville, IL 62226**

**618-222-8900 (Office) 618-222-8950 (Fax)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Family Doctor \_\_\_\_\_

(If same as referring Doctor leave blank)

Reason for Visit \_\_\_\_\_

Mark all of the symptoms and conditions which apply to you even if being treated and under control.

- Chest Pain
- Shortness of Breath
- Dizzy
- Passed Out
- Irregular heart beat
- Fast heart beat
- Swelling in legs or feet
- History of CAD (Blockages in Heart Arteries)
- History of Congestive Heart Failure
- History of Atrial Fibrillation (irregular heart rhythm)
- History of Elevated Cholesterol
- History of Leaky, narrowed or prolapsed valves
- History of a Heart Attack
- History of Diabetes

## Advanced Heart Care, LLC

Have you had any of the following procedures?

Echocardiogram (ultrasound of heart) If so when and where?

\_\_\_\_\_

Stress Test If so when and where? \_\_\_\_\_

Angioplasty (Balloon) or stent placed in your heart arteries. If so when and where? \_\_\_\_\_

Cardioversion (heart shocked back into rhythm) If so when and where?

\_\_\_\_\_

### **MEDICATIONS**

Name                      Dosages (mgs)                      Frequency Taken (i.e. once a day)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

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## ALLERGIES TO MEDICATIONS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## SMOKING

Currently smoke? Yes\_\_\_\_ No\_\_\_\_ Quit\_\_\_\_, If so when\_\_\_\_\_

If yes, how many packs per day? \_\_\_\_\_

How many years have you smoked? \_\_\_\_\_

If no, are you or have you been regularly exposed to second hand smoke? \_\_\_\_\_

## ALCOHOL

Do you drink alcohol? Yes\_\_\_\_ No\_\_\_\_

If yes how much do you drink (Number of alcoholic beverages/weekly) \_\_\_\_\_

## SURGERY

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

## ILLNESSES/CONDITIONS

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Thank you for taking the time to complete this questionnaire. This information will allow us to better care for you. Thanks again.