



COVENTRY
Cardiology Associates

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Pacemakers Pacemaker Clinic Cardiac Catheterization Angioplasty Echos Stress Echos
EKGs Holter Monitors Stress Tests Nuclear Stress Tests Peripheral Vascular Disease

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PLEASE TAKE A MOMENT TO FILL OUT YOUR MEDICAL HISTORY

Name _____

Please list all of your
Medications: _____

Past Medical History and Review

Please circle all that applies

1. High Blood Pressure
2. Heart Disease
3. Cancer
4. Chest Pain
5. Shortness Of Breath
6. Swollen ankles
7. Palpitations
8. Asthma
9. Lightheadedness
10. Nausea
11. Indigestion
12. Unexplained weight loss or gain
13. Headaches
14. Anxiety
15. Depression
16. Alcohol Abuse
17. Drug Abuse
18. Dizziness
19. Stroke
20. Other _____

Operations _____

Hospitalizations _____

Do you smoke? _____