Colorado Mountain Medical
Doctors you know and trust
377 Sylvan Lake Road #210
Eagle, CO 81631
Phone: 970-328-1650
Fax: 970-926-0850

Rebecca E. Laird M.D.
Board Certified in Cardiovascular Disease and Nuclear Cardiology

Patient Intake

Date: _____

Name: _____ Sex: M F DOB: _____ Age: _____

Present Illness (Why are you here today?): _____

Past Cardiovascular History

Disease/Condition	Yes	No	Treatment	Surgery/Procedure	Yes	No	Date(s)
Angina	Yes	No		ECG	Yes	No	
Chest Pain	Yes	No		Pacemaker	Yes	No	
Heart Murmur	Yes	No		Defibrillator	Yes	No	
Palpitations	Yes	No		Cardioversion			
Supraventricular Tachycardia (SVT)	Yes	No		Ablation: Type?	Yes	No	
Atrial Fibrillation	Yes	No		Cardiac Cath: Type?	Yes	No	
Arrhythmia: Type?	Yes	No		Stent(s): Where?	Yes	No	
Loss of Consciousness	Yes	No		Angioplasty	Yes	No	
Heart Attack	Yes	No		Bypass Surgery	Yes	No	
Heart Disease: Type?	Yes	No		Valve Surgery/Repair	Yes	No	
Heart Failure: Type?	Yes	No		Stress Test: Type?	Yes	No	
Coronary Artery Disease	Yes	No		Coronary CT	Yes	No	
Peripheral Vascular Disease (PVD)	Yes	No		Carotid Ultrasound/ Echocardiogram	Yes	No	
Lipid/ Cholesterol Disorder Type?	Yes	No		Holter/event Monitor	Yes	No	
High Blood Pressure	Yes	No		Chest X-ray	Yes	No	
Aneurysm: Type?	Yes	No		Sleep Study	Yes	No	
Edema	Yes	No		Other:	Yes	No	
Stroke/TIA	Yes	No		Other:	Yes	No	
Sleep Apnea	Yes	No		Other:	Yes	No	

Notes: _____

_____

_____

_____

Social / Family History

Social History	Yes	No	Amount/Quit?	Family History	Yes	No	Who?
Alcohol	Yes	No		Heart Failure	Yes	No	
Tobacco	Yes	No		Heart Attack/CAD	Yes	No	
Caffeine	Yes	No		Arrhythmias	Yes	No	
Substance Abuse	Yes	No		Sudden Death	Yes	No	
Cocaine	Yes	No		Alcoholism	Yes	No	
Tattoos	Yes	No		Diabetes	Yes	No	
Blood Transfusions	Yes	No		Blood Clots	Yes	No	
Exercise	Yes	No		High Blood Pressure	Yes	No	
Profession:_____				High Cholesterol	Yes	No	
				Cancer	Yes	No	

Notes:_____

Past Medical / Surgical History

Medical History	Yes	No	Treatment	Surgical History	Yes	No	Date(s)
Arthritis	Yes	No		Orthopedic	Yes	No	
Asthma	Yes	No		Chest	Yes	No	
Bleeding Disorder	Yes	No		Lung	Yes	No	
Blood Clots /Disorder	Yes	No		Stomach	Yes	No	
Cancer, Type:	Yes	No		Intestine/Colon	Yes	No	
Inflammatory Bowel Disease	Yes	No		Gallbladder	Yes	No	
Diabetes	Yes	No		Joint Replacement	Yes	No	
Epilepsy/Seizures	Yes	No		Hysterectomy	Yes	No	
Gallstones	Yes	No		Appendix	Yes	No	
Glaucoma	Yes	No		Prostate	Yes	No	
Headaches	Yes	No		Bladder	Yes	No	
Hepatitis/ Liver Disease	Yes	No		C-Section	Yes	No	
Hiatal Hernia/ GERD	Yes	No		Breast	Yes	No	
Low Blood Pressure	Yes	No		Head	Yes	No	
Kidney Disease	Yes	No		Skin	Yes	No	
Lung Disease	Yes	No		Trauma	Yes	No	
Stomach Problems / Ulcers	Yes	No		Anesthesia Problems	Yes	No	
Thyroid Problems	Yes	No		Other Surgeries	Yes	No	
Tuberculosis	Yes	No		Other Surgeries	Yes	No	
Infectious Disease	Yes	No		Other Surgeries	Yes	No	
Other Disease:	Yes	No		Other Surgeries	Yes	No	

Medications & Allergies: Please include vitamins, herbs, pain relievers and recent antibiotics.

Medications		Allergies	Reaction

Symptom Review

☐ Weight Change	☐ Swelling of Ankles or Legs	☐ Frequent Urination	☐ Anxiety
☐ Fever / Chills	☐ Shortness of Breath	☐ Incontinence	☐ Depression
☐ Poor Vision / Double Vision	☐ Cough	☐ Blood in Urine	☐ Nail Changes
☐ Dry Mouth	☐ Nausea/Vomiting	☐ Blood in Stool	☐ Excessive Thirst
☐ Frequent Nosebleeds	☐ Nasal Congestion	☐ Joint Pain	☐ Easy Bruising
☐ Hearing Loss	☐ Heartburn	☐ Muscle Aches	☐ Excessive Bleeding
☐ Dizziness	☐ Abdominal Pain	☐ New/Chronic Rash	☐ Swollen Lymph Nodes
☐ Fainting	☐ Swallowing Difficulty	☐ Headaches	☐ Hair Loss
☐ Chest Pain	☐ Diarrhea	☐ Seizures	☐ Hot/Cold Sensitivity
☐ Palpitations	☐ Constipation	☐ Memory Loss	☐ Blue Fingers/Toes

Notes/Comments: _____

What Pharmacy do you use?_____

Physicians who are actively treating you:

Doctor: _____

Doctor: _____

Doctor: _____

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:**_____

Provider Check-List

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____