

Cardiovascular Associates of the Peninsula

1720 El Camino Real #100 ♦ Burlingame, California 94010 ♦ (650) 259-5300 ♦ Fax (650) 259-5390

CHEST PAIN EVALUATION FORM

Name: _____ **Date:** _____

DOB: _____

1. How long have you had chest discomfort?
 Less than one week One to two months
 One to two weeks More than six months
 Two to four weeks
2. How long does your chest discomfort last?
 Seconds Hours
 Minutes Continuous
3. Does it occur with exercise? **Yes / No**
4. Does it go away when you stop exercising? **Yes / No**
5. What makes it better? _____
6. Where is your chest pain? _____
7. Does it go up your neck? **Yes / No** Or down your arm? **Yes / No**
8. Does it hurt more when you take a deep breath or cough? **Yes / No**
9. Describe your chest pain:
 Stabbing Tightness
 Burning Heaviness

CARDIAC RISK FACTORS

1. Have you ever smoked? **Yes / No** If so, how many years? ____ When did you quit? ____
2. Does anybody in your family have heart problems? At what age? _____

3. Do you have high blood pressure? **Yes / No**
4. Do you have high cholesterol? **Yes / No**
5. Do you have diabetes? **Yes / No**
6. Have you ever had radiation therapy to your chest before? **Yes / No**
7. What medicines are you taking now? _____

8. Do you have acid indigestion or heartburn? **Yes / No**
9. How much do you weigh? _____