Please fill out before your visit with the doctor today

Name _____ Date of Birth _____

Have you recently had any of the following:

Labs	yes	no	Date: _____	Where: _____
EKG	yes	no	Date: _____	Where: _____
X-ray	yes	no	Date: _____	Where: _____
Heart Surgery	yes	no	Date: _____	Where: _____
ER Visit / Hospitalization	yes	no	Date: _____	Where: _____
Echo / Ultrasounds	yes	no	Date: _____	Where: _____
Other	yes	no	Date: _____	Where: _____