Gopala Krishna Rao, M.D., M.R.C.P., R.P.V.I., F.A.C.C.

Board Certified in Cardiology, Echocardiography & Vascular Interpretation

Patient Name: **DOB:**

Referring M.D.:

1. Reason for visit/chief complaint –

2. Cardiac Risk Factors – Please circle

Diabetes Mellitus	High Blood Pressure	High Cholesterol	Smoking	Family History

3. Have you had a heart attack, angiogram, stent procedure or bypass surgery?

4. Have you had a stroke, poor circulation, stent/angioplasty procedure on your neck or lower extremity blood vessels?

5. Any history of congestive heart failure/weak heart, heart rhythm problems or pacemaker/defibrillator procedures in the past?

6. List other medical problems –

7. List prior surgeries –

8. Allergies –

9. Smoking (Y / N) If yes, how long and how many per day?
   Alcohol / Drug use? (Y / N)

10. Family history of heart problems?

11. Medication list -

MEDICATION FLOWSHEET

1305 Airport Freeway, Suite 424, Bedford, TX 76021
Phone: 817-510-1060 Fax: 817-510-9940

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Patient Name:		**Allergies:**
Date	**Medication**	**Refills**
Start / Stop	Dosage/Direction/Amount	Date/Amount/Initials
Start / Stop		
Start / Stop		
Start / Stop		
Start / Stop		
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