Westside Medical Associates of Los Angeles

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Tel. (310) 623-1150
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Patient Name Last ____________ First ____________ Middle ____________

Address 1 ____________

Address 2 ____________ Home Phone # ____ - ____ - ____

City ____________ Social Security # ____ - ____ - ____

State ____________ ZIP ____________ M ☐ F ☐

Birth Date ____________ Age ______ Email address: ____________

How did you hear about us? ____________

Employer ____________ Work Phone # ____________

Employer Address ____________

City ____________ State ______ ZIP ______

Person to Contact in an Emergency ____________ Phone # ____________

Primary Care Physician Last ____________ First ____________ M.I. ____

Address ____________ City ____________

State ______ ZIP ______ Phone # ____________

Patient Medical History

1. Please answer the following questions about your height and weight.

What is your current weight? ☐☐☐ lb. What is your current height? ☐ ft. ☐☐ in.

2. Have you ever had a problem with any of the symptoms or conditions listed below?

	Yes	No
Chest pain or pressure	☐	☐
Chest pain or pressure with exertion	☐	☐
Fainting or lightheadedness	☐	☐
Atrial Fibrillation or irregular heartbeats	☐	☐
High blood pressure	☐	☐
Diabetes / high blood sugar	☐	☐
Asthma or Wheezing	☐	☐
Chronic cough or Bronchitis	☐	☐
Pneumonia	☐	☐
Tuberculosis (TB)	☐	☐
Positive TB test (+ PPD)	☐	☐
Unusual fatigue	☐	☐

Please continue onto Page 2

Westside Medical Imaging

3. Have you had any of the following diagnostic/therapeutic studies?

	Yes	No	Normal	Abnormal	Year
Treadmill (ECG) Stress Test	☐	☐	☐	☐	☐☐☐☐
Nuclear Test of the Heart (PET Scan)	☐	☐	☐	☐	☐☐☐☐
Angioplasty Procedure (Balloon)	☐	☐			☐☐☐☐
Atherectomy Procedure ("Roto-Rooter")	☐	☐			☐☐☐☐
Arterial Stent Placement	☐	☐			☐☐☐☐
Coronary Artery Bypass Surgery	☐	☐			☐☐☐☐
Nuclear Test of the Heart (Thallium)	☐	☐	☐	☐	
Heart Catheterization (Coronary Angiogram)	☐	☐	☐	☐	
Ultrasound of the Heart (Echocardiogram)	☐	☐			

If yes, have you ever had a heart echo at this office ? **Yes** ☐ **No** ☐

Have you ever had a heart echo at another office ? **Yes** ☐ **No** ☐ ☐☐☐☐

Have you ever been told you had a problem with a heart valve ? **Yes** ☐ **No** ☐

4. Are you allergic to any of the following?

	Yes	No
Are you allergic to any Medications?	☐	☐
Are you allergic to iodine/shellfish?	☐	☐
Are you allergic to aspirin?	☐	☐
Other?	☐	☐
Have you ever had a reaction to contrast (dye) from an X-ray or CAT scan procedure?	☐	☐

5. Have you ever been diagnosed with High Cholesterol by a physician ? **Yes** ☐ **No** ☐

Cholesterol: High ☐ O.K. ☐

(Treated) Total Cholesterol ☐☐☐ HDL ☐☐☐ LDL ☐☐☐

(Untreated) Total Cholesterol ☐☐☐ HDL ☐☐☐ LDL ☐☐☐

Triglycerides: High ☐ O.K. ☐

(Treated) Total Triglycerides ☐☐☐

(Untreated) Total Triglycerides ☐☐☐

What year last measured? ☐☐☐☐

6. Have you had any of the following diseases? When were they first diagnosed?

	Yes	No	Year
Heart Attack	☐	☐	☐☐☐☐
Stroke	☐	☐	☐☐☐☐
Emphysema	☐	☐	☐☐☐☐
Osteoporosis	☐	☐	☐☐☐☐
Kidney Disease or Kidney Failure	☐	☐	☐☐☐☐
Cancer: ______________________	☐	☐	☐☐☐☐
Other: ______________________	☐	☐	☐☐☐☐

Please continue onto Page 3

Westside Medical Imaging

7. Have you had any of the following surgeries? When were they performed?

	Yes	No	Year	More Details
Gall Bladder Surgery	☐	☐	☐☐☐☐	
Breast Surgery	☐	☐	☐☐☐☐	
Abdominal Surgery	☐	☐	☐☐☐☐	________
Heart Surgery	☐	☐	☐☐☐☐	________
Chest Surgery	☐	☐	☐☐☐☐	________
Other Surgery	☐	☐	☐☐☐☐	________

8. Please list current medications. Check the category for which they are prescribed.

Name	Heart	Stomach	Blood Pressure	Mood	Hormone	Other	Number of Years
1. ________	☐	☐	☐	☐	☐	☐	☐☐
2. ________	☐	☐	☐	☐	☐	☐	☐☐
3. ________	☐	☐	☐	☐	☐	☐	☐☐
4. ________	☐	☐	☐	☐	☐	☐	☐☐
5. ________	☐	☐	☐	☐	☐	☐	☐☐
6. ________	☐	☐	☐	☐	☐	☐	☐☐
7. ________	☐	☐	☐	☐	☐	☐	☐☐

9. Please answer the following questions about your family's disease history.

	Heart Attack	Stroke	Breast Cancer	Colon Cancer	Other Cancer	Diabetes	Age of Onset	If Deceased, Age of Death
Father	☐	☐	☐	☐	☐	☐	☐☐	☐☐
Mother	☐	☐	☐	☐	☐	☐	☐☐	☐☐
Sibling M ☐ F ☐	☐	☐	☐	☐	☐	☐	☐☐	☐☐
Sibling M ☐ F ☐	☐	☐	☐	☐	☐	☐	☐☐	☐☐
Sibling M ☐ F ☐	☐	☐	☐	☐	☐	☐	☐☐	☐☐
Grandparents	☐	☐	☐	☐	☐	☐		

10. Please answer the following questions about your life style habits.

Do you currently use tobacco? Yes ☐ No ☐ Have you used tobacco in the past? Yes ☐ No ☐

If yes, how many years? ☐☐ If yes, how many years since you quit? ☐☐

Do you drink alcohol more than 4 times a week ? Yes ☐ No ☐

Do you exercise more than 30 minutes a day at least 5 days a week ? Yes ☐ No ☐

Have you ever been diagnosed with Erectile Dysfuncion by a physician ? Yes ☐ No ☐

Thank you for allowing **Westside Medical Imaging** to better serve you.