

Texas Cardiology Associates of Houston

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Cardiology
Interventional Cardiology
Board Certified

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Patient Name: _____ Date of Birth: _____

General/Constitutional

Headache	<input type="radio"/> Yes	<input type="radio"/> No
Fever	<input type="radio"/> Yes	<input type="radio"/> No
Fatigue	<input type="radio"/> Yes	<input type="radio"/> No
Chills	<input type="radio"/> Yes	<input type="radio"/> No
Change in appetite	<input type="radio"/> Yes	<input type="radio"/> No
Sleep disturbance	<input type="radio"/> Yes	<input type="radio"/> No
Lightheadedness	<input type="radio"/> Yes	<input type="radio"/> No
Weight gain	<input type="radio"/> Yes	<input type="radio"/> No
Weight loss	<input type="radio"/> Yes	<input type="radio"/> No
Night sweats	<input type="radio"/> Yes	<input type="radio"/> No

Cardiovascular

Chest pain at rest	<input type="radio"/> Yes	<input type="radio"/> No
Chest pain with exertion	<input type="radio"/> Yes	<input type="radio"/> No
Difficulty lying flat	<input type="radio"/> Yes	<input type="radio"/> No
Dizziness	<input type="radio"/> Yes	<input type="radio"/> No
Irregular heartbeat	<input type="radio"/> Yes	<input type="radio"/> No
Shortness of breath at rest	<input type="radio"/> Yes	<input type="radio"/> No
Weakness	<input type="radio"/> Yes	<input type="radio"/> No
Palpitations	<input type="radio"/> Yes	<input type="radio"/> No
Cyanosis	<input type="radio"/> Yes	<input type="radio"/> No
Shortness of breath on exertion	<input type="radio"/> Yes	<input type="radio"/> No
Swelling in legs	<input type="radio"/> Yes	<input type="radio"/> No

Respiratory

Cough	<input type="radio"/> Yes	<input type="radio"/> No
Pain with inspiration	<input type="radio"/> Yes	<input type="radio"/> No
Short of breath at rest	<input type="radio"/> Yes	<input type="radio"/> No
Short of breath with exertion	<input type="radio"/> Yes	<input type="radio"/> No
Sputum production	<input type="radio"/> Yes	<input type="radio"/> No
Wheezing	<input type="radio"/> Yes	<input type="radio"/> No

Peripheral Vascular

Pain/cramping in legs after exertion	<input type="radio"/> Yes	<input type="radio"/> No
Absent pulses in hands	<input type="radio"/> Yes	<input type="radio"/> No
Cold extremities	<input type="radio"/> Yes	<input type="radio"/> No
Absent pulses in feet	<input type="radio"/> Yes	<input type="radio"/> No