



Echocardiogram / Carotid Doppler History

Name / Nombre: _____

Social Security Number: _____

Today's Date / Fecha: _____ / _____ / _____

Height / Estatura: _____ Weight/ Peso: _____ Allergies/Alergias: _____

Do you have any history of the following?

Tiene usted historia de lo siguiente?

- | | | |
|---|-----------------------------|-----------------------------------|
| Coronary Artery Disease/ Arteria Coronaria | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Heart Attack / Ataque del Corazon | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Coronary Angioplasty / Angioplastia Coronaria | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Angina | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| High Blood Pressure / Presion Alta | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Diabetes | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| High Cholesterol / Colesterol Alto | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |

Do you do any of the following? (Please specify amount)

Consume usted lo siguiente? (Por Favor epecifique la cantidad)

- | | | |
|---|-----------------------------|-----------------------------------|
| Smoke / Fuma | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Drink Coffee and/ or Tea / Toma Café o Te | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Drink Alcohol / Toma Alcol | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Follow a specific Diet / Sigue una Dieta Especifica | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Low Fat / Baja en Grasa | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Low Salt / Baja en Sal | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Low Sugar / Baja en Azucar | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |

Have you experienced any of the following?

Tiene alguno de estos síntomas?

- | | | |
|--|-----------------------------|-----------------------------------|
| Chest pain / Dolor en el Pecho | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Chest Discomfort / Incomodidad en el Pecho | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Chest Pressure / Presion en el Pecho | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Shortness of Breath / Falta de Aire | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Palpitations / Palpitaciones | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Leg Pain / Dolor en las Piernas | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Dizziness / Mareo | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Faint Spells / Desmallos | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Nausea or Vomiting / Nausea o Vomito | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Headaches / Dolores de Cabeza | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Blurred Vision / Vision Borrosa | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Tingling and/or Numbness in arms or legs | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |
| Piernas or Brasos Entumido o Calambre | <input type="checkbox"/> NO | <input type="checkbox"/> YES / SI |