# 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 siguente?** | |
|---|---|---|
| Coronary Artery Disease/ Arteria Coronaria | □ NO | □ YES / SI |
| Heart Attack / Ataque del Corazon | □ NO | □ YES / SI |
| Coronary Angioplasty / Angioplastia Coronaria | □ NO | □ YES / SI |
| Angina | □ NO | □ YES / SI |
| High Blood Pressure / Presion Alta | □ NO | □ YES / SI |
| Diabetes | □ NO | □ YES / SI |
| High Cholesterol / Colesterol Alto | □ NO | □ YES / SI |

**Do you do any of the following? (Please specify amount)**
**Consume usted lo siguiente? (Por Favor epecifique la cantidad)**

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

| **Have you experienced any of the following?** | **Tiene alguno de estos síntomas?** | |
|---|---|---|
| Chest pain / Dolor en el Pecho | □ NO | □ YES / SI |
| Chest Discomfort / Incomodidad en el Pecho | □ NO | □ YES / SI |
| Chest Pressure / Presion en el Pecho | □ NO | □ YES / SI |
| Shortness of Breath / Falta de Aire | □ NO | □ YES / SI |
| Palpitations / Palpitaciones | □ NO | □ YES / SI |
| Leg Pain / Dolor en las Piernas | □ NO | □ YES / SI |
| Dizziness / Mareo | □ NO | □ YES / SI |
| Faint Spells / Desmallos | □ NO | □ YES / SI |
| Nausea or Vomiting / Nausea o Vomito | □ NO | □ YES / SI |
| Headaches / Dolores de Cabeza | □ NO | □ YES / SI |
| Blurred Vision / Vision Borrosa | □ NO | □ YES / SI |
| Tingling and/or Numbness in arms or legs | □ NO | □ YES / SI |
| Piernas or Brasos Entumido o Calambre | □ NO | □ YES / SI |