

Patient Record

Date: _____

Institution: _____ - Insurance: _____

Name: _____

Job: _____ Tel/Cel.: _____

Gender: Female () Male () Other ()

Age: _____ years Birthdate: ____/____/____

1. Have you ever done any Electrocardiogram before?? Yes () No ()

1.1 If so, why was it indicated? _____

2. Do you smoke? Yes () No () Quit () 2.1 How long did you smoke? _____

3. Do you drink? Yes () No () Quit () 3.1 How long did you drink? _____

4. Do you use drugs? Yes () No () Quit () 4.1 Wich one and how long did you used? _____

5. Do you practice any kind of exercise and / or sport? Yes () No ()

Walk ()

Jogging ()

Run ()

Zumba ()

Dancing ()

Biking ()

Lifting weight ()

Other _____

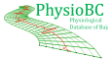
5.1 Where do you practice?

Home ()

Park ()

Gym ()

Other _____



6. Do you have any chronic illness? Yes () No ()

7. Pathological personal history

High blood pressure ()
Diabetes Mellitus ()
Hypercholesterolemia ()
Hyperthyroidism ()
Hypothyroidism ()
Cardiopathy ()
Other

8. Hereditary Family Background

High blood pressure ()
Diabetes Mellitus ()
Hypercholesterolemia ()
Hyperthyroidism ()
Hypothyroidism ()
Cardiopathy ()
Other

9. Do you take any medication? Yes () No ()

9.1 In case of yes, which one? _____

10. Have you suffered from a heart attack? Yes () No ()

Vital Signs:

Heart rate _____ x'
Breathing rate _____ x'
Blood presssure _____ mmHg
pSO2 _____ %

Physical Exploration:

Weight: _____ Kg.
Height: _____ cm.
Waist: _____ cm.
Hips: _____ cm.
BMI: _____

Cardiax:

Pax: _____
QRSax: _____
Tax: _____
Pd: _____
PQ: _____
QRS: _____
QT: _____
QTcB: _____