

GSO: _____
 App. No: _____

Name _____ Date of Birth _____

For question 1, 2, 3, 4 and 5 circle "Yes" or "No" for each item listed:

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. Have you ever had any of the following:</p> <p>(a) Chest pain yes no</p> <p>(b) Palpitations yes no</p> <p>(c) Skipping of the heart yes no</p> <p>(d) Shortness of breath yes no</p> | <p>4. What was the nature of the pain:</p> <p>(a) Constricting or pressure yes no</p> <p>(b) Dull yes no</p> <p>(c) Acute yes no</p> <p>(d) Constant yes no</p> <p>(e) Intermittent yes no</p> |
| <p>2. Was pain located at:</p> <p>(a) Middle of chest yes no</p> <p>(b) Left side yes no</p> <p>(c) Left shoulder or arm yes no</p> <p>(d) Right shoulder or arm yes no</p> <p>(e) Neck and/or jaw yes no</p> | <p>5. Was there a diagnosis made of any of the following:</p> <p>(a) Myocardial infarction yes no</p> <p>(b) Coronary insufficiency yes no</p> <p>(c) Angina yes no</p> <p>(d) Not heart related yes no</p> |
| <p>3. Was pain associated with:</p> <p>(a) Exertion yes no</p> <p>(b) Emotion yes no</p> <p>(c) Exposure to cold yes no</p> <p>(d) After food yes no</p> <p>(e) Sweating yes no</p> | |

If pain was not heart related, provide final diagnosis _____

If you have answered any of the previous questions "yes" please answer the following:

6. What was the date of the first attack? _____
7. What was the date of the last attack? _____
8. How often have you had attacks? _____
9. How long did each attack last? _____
10. Were you confined to bed? If so, how long? _____
11. Were you hospitalized? If so, when, what hospital and for how long? _____
12. Did you lose any time from work? If so, when and for what period? _____
13. Have you had a recurrence of symptoms since bed confinement? _____
14. What medication, if any, do you take? _____
15. Give name and address of physician seen at time of original attack. _____
16. Give name and address of current attending physician. _____
17. Give name and address of physician who completed last Electrocardiogram as well as date it was taken. _____