Garden City Hospital

Center for Sleep Disorders
Specialty Centers of Westland
35600 Central City Parkway, Suite 103
Westland, MI 48185
Phone: 734-458-3330 Fax: 734-458-3331

Cardiac History

NAME: _____ SDC#: _____

1. Are you on oxygen? ☐ No ☐ Yes, _____ **liters/min: continuous or not?**

2. Have you ever had a heart attack? ☐ No ☐ Yes, _____ **date(s)**

3. Have you ever had an angioplasty? ☐ No ☐ Yes, _____ **date(s)**

4. Have you ever had a heart catheterization? ☐ No ☐ Yes, _____ **date(s)**

5. Do you have a pacemaker/AICD? ☐ No ☐ Yes

6. Do you have high blood pressure? ☐ No ☐ Yes

7. Do you ever have:
   - chest pain? ☐ No ☐ Yes
   - irregular heart beats? ☐ No ☐ Yes
   - atrial fibrillation? ☐ No ☐ Yes
   - rapid heart beat? ☐ No ☐ Yes

7. Are you under the care of a cardiologist? ☐ No ☐ Yes

_____
Cardiologist Name

_____
Address

_____
City, State

8. Do you take any medication for your heart? ☐ No ☐ Yes