Patient Registry Form

Date: _____

Name: _____ **Age** _____ **Sex** _____

Phone Number: _____

Email: _____

Primary care doctor: _____

Cardiologist: _____

Check the box if you have (now or in the past) any of the following conditions:

Please record the year you were first diagnosed.

- ☐ **Heart failure** **Year** _____
- ☐ **Heart murmur** **Year** _____
- ☐ **Enlarged heart** **Year** _____
- ☐ **Heart defect from birth** **Year** _____
- ☐ **High blood pressure** **Year** _____
- ☐ **Heart attack** **Year** _____
- ☐ **Heart surgery** **Year** _____
- ☐ **Stroke** **Year** _____
- ☐ **Heart cath** **Year** _____
- ☐ **Atrial fibrillation** **Year** _____
- ☐ **Arrhythmias (abnormal heart rhythms)** **Year** _____
- ☐ **Pacemaker/Defibrillator implant** **Year** _____
- ☐ **Diabetes** **Year** _____
- ☐ **Kidney disease** **Year** _____
- ☐ **Cancer** **Year** _____ **Type** _____
- ☐ **Peripheral vascular disease** **Year** _____
- ☐ **High cholesterol** **Year** _____
- ☐ **Smoking** **Total no. of years** _____
- ☐ **Liver disease** **Year** _____
- ☐ **Other** _____

Please print, complete and mail this form to:

Jackson Heart Clinic
Research Department
970 Lakeland Drive, Ste. 61
Jackson, MS 39216