CARDIOVASCULAR NEW PATIENT MEDICAL HISTORY

Today's date: ______________________________

Patient Name: ____ DOB: ______________________________

Reason for referral: ____

CARDIAC HISTORY:

Have you ever had a cardiac catheterization? _____ Yes _____ No

If yes, when: ________________________________ Where: _________________________________

CARDIOVASCULAR:

_____ Chest pain or angina

_____ Shortness of breath

_____ Irregular heartbeat/arrhythmia

_____ Fast heart beat

_____ Dizziness

_____ Passing out/syncope

_____ Swelling of feet/ankles or hands

_____Leg pain when walking/claudication

_____ Heart Murmur

_____ Rheumatic fever

_____ Myocardial Infarction (heart attack)

_____ Enlarged heart/heart failure

_____ Coronary artery disease

_____ Blood clot in heart, lungs, or leg

_____ Aneurysm

_____ Scarlet fever

MEDICAL HISTORY

Do you have an Advanced Directive: _____ Yes _____ No

If not, would you like one: _____ Yes _____ No

List all medical conditions:

____

____

____

List all past surgical procedures:

____

____

MEDICATIONS

List all medications, strength and how you take them:

____

____

____

____

ALLERGIES

List all allergies and your reaction to the medications:

____

____

____

Are you allergic to iodine dye? _____ Yes _____ No

SOCIAL HISTORY

Do you currently smoke cigarettes? _____ Yes _____ No If yes, how many packs per day? ______

Have you quit smoking? _____ Yes _____ No If yes, when? ____________________________

Do you have any serious intentions of quitting? _____ Yes _____ No

How many years did you smoke? ________________

Does your spouse smoke? _____ Yes _____ No

Do you drink alcohol? _____ Yes _____ No If yes, how much? ______________________________

Do you drink beverages containing caffeine? _____ Yes _____ No If yes, how much? _____________

Do you use illicit drugs? _____ Yes _____ No

Do you use any herbal supplements? _____ Yes _____ No

If yes, please list:

____

Do you have any hobbies? _____ Yes _____ No

If yes, please tell us:

____

Do you exercise? _____ Yes _____ No If yes, how often? ______________________________

Are you under any unusual stress in your life? _____ Yes _____ No

If yes, please

explain:____

____

FAMILY HISTORY

Heart attack _____ Yes _____ No If yes, relationship: ______________________________

Stroke _____ Yes _____ No If yes, relationship: ______________________________

Coronary Artery Disease _____ Yes _____ No If yes, relationship: ______________________________

Bypass surgery _____ Yes _____ No If yes, relationship: ______________________________

Diabetes _____ Yes _____ No If yes, relationship: ______________________________

High Blood Pressure _____ Yes _____ No If yes, relationship: ______________________________

Sudden death _____Yes _____ No If yes, relationship: ______________________________

MEDICAL SYSTEM REVIEW

Head & Neck

_____ Frequent headaches
_____ Neck pain
_____ Need glasses
_____ Blurry vision
_____ See double
_____ Eye pain or watering
_____ Hearing difficulties
_____ Buzzing in ears
_____ Dental or gum trouble
_____ Soreness in mouth
_____ Hoarse voice
_____ Frequent nose bleeds

Digestive

_____ Loss of appetite
_____ Difficulty swallowing
_____ Heartburn

Respiratory

_____ Shortness of breath
_____ Wheezing or asthma
_____ Cough up phlegm
_____ Cough up blood
_____ Pain in chest with breathing

Endocrine

_____ Thyroid disease
_____ Diabetes
_____ Change in tolerance to heat and cold

Urinary-Genital

_____ Frequent urination (day/night)
_____ Burning on urination
_____ Difficulty starting urine

_____ Nausea or Vomiting
_____ Vomiting blood
_____ Stomach pain
_____ Ulcer
_____ Constipation
_____ Diarrhea
_____ Change in bowel habits
_____ Black or bloody bowel movements
_____ Rectal pain
_____ Recent unintended weight loss
_____ Recent unintended weight gain

Neurological
_____ Numbness or paralysis
_____ Seizures
_____ Tremor
_____ Difficulty sleeping
_____ Difficulty with speech or memory
_____ Depression
_____ Anxiety

_____ Blood in urine
_____ Kidney stones
_____ Incontinence
_____ Sexual dysfunction

Musculoskeletal
_____ Aching muscles or joints
_____ Swollen joints
_____ Back or shoulder pain
_____ Arthritis
_____ Weakness in arm

Hematological
_____ Anemia or blood clot disorder
_____ Excessive bleeding or bruising
_____ Clotting problem