Health History - Cardiology

Name: ______________________ **DOB:** ____________

Preferred Name (Nickname): ______________________

Pharmacy Name: ______________________ **Pharmacy Address:** ______________________

PCP/Referring Provider Name: ______________________

List of all doctors you see (Care Team): ______________________

Reason for today's visit: ______________________

When did your symptoms begin? ______________________

What triggers your symptoms? ______________________

What makes your symptoms better? ______________________

Grade your pain 0-10 (0= no pain and 10=worst pain): ______________________

What treatment have you had for your symptoms? ______________________

ALLERGIES List all allergies to medications or foods and your reaction:

ALLERGY	REACTION

MEDICATIONS Please list all medicines you are currently taking (include over the counter such as vitamins):

NAME OF MEDICATION	DOSAGE	HOW OFTEN PER DAY

FAMILY HISTORY Please list any relative with the following medical problems and their relationship to you:

	Relation		Relation
☐ Adopted		☐ Heart Disease	
☐ Alcoholism		☐ High Blood Pressure	
☐ Anemia		☐ High Cholesterol	
☐ Aortic Aneurysm		☐ History of Emphysema	
☐ Arthritis		☐ Kidney Disease	
☐ Asthma		☐ Liver Problem	
☐ Blood Clotting Disorder		☐ Migraine	
☐ Congestive Heart Failure		☐ Peripheral Vascular Disease	
☐ COPD		☐ Pulmonary Embolism	
☐ Deep Vein Thrombosis		☐ Sleep Apnea	
☐ Diabetes Mellitus		☐ Stroke	
☐ Family History of Cancer		☐ Substance Abuse	
☐ Heart Attack		☐ Sudden Death	

SOCIAL HISTORY

Employment	Occupation: Employer:
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner
Number of Children	
Sexually Active	☐ Yes ☐ No
Diet	☐ Regular ☐ Vegetarian ☐ Gluten Free ☐ Carbohydrate ☐ Cardiac ☐ Diabetic
Tobacco Use	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long? _______________ Year Quit: ____________ ☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/day
Alcohol Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? ____
Caffeine Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day _______________
Illicit Drug Use/Abuse	☐ Yes ☐ No Drug Abuse Type: __________________ Illicit drug years of use: ___________________
Advance directive?	☐ Yes ☐ No

PAST SURGICAL HISTORY Have you ever had the following:

	Year		Year		Year
☐ AICD		☐ Cystoscopy		☐ Pacemaker	
☐ Abdominal Surgery		☐ Device Implant		☐ Percutaneous Transluminal Coronary Angioplasty	
☐ Ablation		☐ ELG/Abdominal Aortic Aneurysm Repair		☐ Prostate Surgery	
☐ Amputation		☐ Eye Surgery		☐ Pseudoaneurysm Repair	
☐ Appendectomy		☐ Gallbladder Surgery		☐ Spine Surgery	
☐ Arthroscopic Surgery		☐ Gyn Surgery		☐ Thyroid Surgery	
☐ Back Surgery		☐ Head or Neck Surgery		☐ Tonsillectomy	
☐ Bariatric Surgery		☐ Heart Surgery		☐ Tubal Ligation	
☐ Bladder Surgery		☐ Heart Transplant		☐ Vascular Surgery	
☐ Breast Implants		☐ Implantable Defibrillator		☐ Vein Stripping	
☐ Breast Surgery		☐ Inguinal Hernia Repair		☐ Other Surgeries:	
☐ Cancer Surgery		☐ Intestinal Surgery-Colostomy			
☐ Cardiac Surgery		☐ Joint Replacement			
☐ Cardioversion		☐ Kidney Surgery			
☐ Carotid Endarterectomy		☐ Lung Surgery			
☐ Cataract Surgery		☐ Neurosurgery			
☐ Colon Surgery		☐ Orthopedic Surgery			
☐ Coronary Stent Placement		☐ Ovary Removal			

Any other Medical/Surgical history/conditions, please inform the nurse.

PAST MEDICAL HISTORY Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

	Yes	No		Yes	No
Arrhythmias	☐	☐	Hyperlipidemia	☐	☐
Arthritis	☐	☐	Hypertension	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Atrial Fibrillation	☐	☐	Liver Disease/Hepatitis	☐	☐
Atrial Flutter	☐	☐	Lung Disease	☐	☐
Bradycardia	☐	☐	Myocardial Infarction	☐	☐
Cancer	☐	☐	Overweight/Obesity	☐	☐
Cardiomyopathy	☐	☐	Palpitations	☐	☐
Carotid Disease	☐	☐	Peripheral Vascular Disease	☐	☐
Chronic Venous Insufficiency	☐	☐	Pneumonia	☐	☐
Congestive Heart Failure	☐	☐	Pulmonary Embolism	☐	☐
COPD	☐	☐	Renal Artery Stenosis	☐	☐
Coronary Artery Disease	☐	☐	Stroke/TIA	☐	☐
Depression	☐	☐	Thyroid Disease	☐	☐
Diabetes Type 1	☐	☐	Valvular Heart Disease	☐	☐
Diabetes Type 2	☐	☐	Varicose Veins	☐	☐
DVT	☐	☐	Other:		
Endocarditis	☐	☐			
Heart Disease	☐	☐			

Review of Systems

Check all that apply:

Constitutional

☐ Yes ☐ No Fever
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Weakness
☐ Yes ☐ No Weight Loss
☐ Yes ☐ No Weight Gain

HEENT

☐ Yes ☐ No Difficulty Hearing
☐ Yes ☐ No Ear Pain
☐ Yes ☐ No Frequent Nosebleeds
☐ Yes ☐ No Nose/Sinus Problems
☐ Yes ☐ No Bloodshot Eyes
☐ Yes ☐ No Worsening Vision
☐ Yes ☐ No Burning of Eyes

Cardiovascular

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Arm Pain on Exertion
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Lightheaded
☐ Yes ☐ No Calf or Jaw Pain
☐ Yes ☐ No Syncope
☐ Yes ☐ No Leg Swelling
☐ Yes ☐ No Leg Pain/Claudication
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Cool Extremities

Respiratory

☐ Yes ☐ No Cough
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Snoring
☐ Yes ☐ No Coughing up Blood
☐ Yes ☐ No COPD

Gastrointestinal

☐ Yes ☐ No Nausea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Heartburn
☐ Yes ☐ No Abdominal Swelling
☐ Yes ☐ No Bleeding

Genitourinary

☐ Yes ☐ No Difficulty Urinating
☐ Yes ☐ No Increased Frequency
☐ Yes ☐ No Blood in Urine
☐ Yes ☐ No Bladder Incontinence

Musculoskeletal

☐ Yes ☐ No Muscle Aches
☐ Yes ☐ No Muscle Cramps
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Back Pain

Skin

☐ Yes ☐ No Rashes
☐ Yes ☐ No Blisters
☐ Yes ☐ No Irritation of the Skin

Neurologic

☐ Yes ☐ No Weakness
☐ Yes ☐ No Numbness
☐ Yes ☐ No Seizures
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Headaches
☐ Yes ☐ No Memory Lapses
☐ Yes ☐ No Loss of Balance or Falls
☐ Yes ☐ No Confusion

Psychiatric

☐ Yes ☐ No Depression
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Panic Attacks
☐ Yes ☐ No Sleep Disturbances
☐ Yes ☐ No Thoughts of Suicide
☐ Yes ☐ No Hallucinations

Endocrine

☐ Yes ☐ No Hair Changes
☐ Yes ☐ No Tremors
☐ Yes ☐ No Goiter

Hematologic/Lymphatic

☐ Yes ☐ No Bruising
☐ Yes ☐ No Anemia
☐ Yes ☐ No Easy Bleeding

Allergic/Immunologic

☐ Yes ☐ No Asthma
☐ Yes ☐ No Eczema
☐ Yes ☐ No Allergies