

MEDICAL HISTORY

Please complete the following information to the best of your ability. If you are unsure about a question, or how to reply to a specific question, please notify our clinical staff. Thank you.

NAME _____ AGE _____ SEX _____

DATE _____ PHONE # _____

PCP _____ REFERRING DR. _____

REASON FOR VISIT _____

CARDIOVASCULAR

1. Have you ever been told that you have heart disease? Yes No

Have you had any of the following?

1. Heart attack? Yes No If yes, date(s) _____

2. Pain, pressure or tightness in chest, neck, arms, jaw or upper back?
 Yes No

A. Pain first started:

_____ days ago _____ months ago
_____ weeks ago _____ years ago

B. Frequency, severity, pattern of discomfort has been at its current level for:

_____ days _____ months
_____ weeks _____ years

C. Current frequency of pain:

_____ episodes per day _____ episodes per month
_____ episodes per week _____ episodes per year

D. Pain occurs with:

Walking _____	With sexual activity _____
Emotion/Stress _____	Housework or yard-work _____
At rest _____	After meals _____

1. Have you ever had congestive heart failure? yes no
2. Have you ever had shortness of breath with mild exertion? yes no
3. Have you ever awakened at night because of shortness of breath? yes no
4. Have you ever had swelling of the ankles or feet? yes no
5. Have you ever had rheumatic fever or rheumatic heart disease? yes no
6. Have you ever had high blood pressure? yes no
7. Have you ever had palpitations, skips or irregular heartbeats? yes no
8. Have you ever had blackouts, fainting spells, dizzy spells or light-headedness? yes no
9. Have you ever had pains or cramps in legs (especially in calves) while walking? yes no
10. Do you have a history of phlebitis, varicose veins or blood clots in veins of legs? yes no
11. Do you have a history of a heart murmur? yes no

Have you had any of the following tests?

1. Exercise test (stress test) ? Date(s)_____ yes no
2. Echocardiogram? Date(s)_____ yes no
3. Heart catheterization? Date(s)_____ yes no
Hospital / M.D. _____
4. Peripheral angiogram or arteriogram?Date(s)_____ yes no
5. Ultrasound or Vascular studies of the neck or extremity arteries? Date(s) _____ yes no

Have you ever had any of the following procedures?

- 1. Have you ever had heart surgery? [] yes [] no
What type _____
Date(s) _____
Hospital(s) _____

- 2. Have you ever had varicose vein surgery? [] yes [] no

- 3. Have you ever had surgery on arteries other than in the heart? [] yes [] no
What type _____
Date(s) _____
Hospital(s) _____

- 4. Do you have a pacemaker or implantable defibrillator (AICD) ? [] yes [] no

ALLERGIES

- 1. Do you have allergies or sensitivities to medications? [] yes [] no
If so, list drug(s) and describe the reaction:

MEDICATIONS

Current Medications. List all names, dosages and frequency:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

PAST MEDICAL HISTORY

1. Have you ever had an operation? yes no

2. If so, what type(s)? _____

FAMILY HISTORY

Father: Living yes no
Age or age at death (circle) _____
Cause of death _____

Mother: Living yes no
Age or age at death (circle) _____
Cause of death _____

Brothers: Living yes no
Age or age at death (circle) _____
Cause of death _____

Sisters: Living yes no
Age or age at death (circle) _____
Cause of death _____

Children: Living yes no
Age or age at death (circle) _____
Cause of death _____

Please circle illnesses in blood relatives (mother/ father/ brother/sister) :

Diabetes

High blood pressure

Heart disease

Kidney disease

Cancer

High cholesterol / triglycerides

Stroke

Bleeding disorder

Other: _____

SOCIAL HISTORY

Date of Birth: _____

Occupation: _____ Retired: yes no

State(s) of residence: _____

Do you smoke cigarettes? yes no

If so, _____ Packs per day for _____ years.

Stopped when? _____

Do you consume alcoholic beverages? yes no

If so, what type? _____

_____ Drinks per day or week (circle)

REVIEW OF SYSTEMS

HEAD, EARS, EYES, NOSE, THROAT AND MOUTH

1. Do you wear glasses/contacts? yes no
2. Do you have glaucoma? yes no
3. Do you have cataracts? yes no
4. Do you have visual disturbances?
(i.e. double vision, temporary vision loss) yes no
5. Do you have a hearing problem? yes no
6. Do you wear a hearing aid? yes no
7. Do you wear dentures? yes no
8. Do you have mouth or gum problems? yes no

NEUROPSYCHIATRIC

1. Have you had a stroke? yes no
2. Have you had any muscle disorders / cramps? yes no
3. Do you have headaches? yes no
4. Have you ever had any psychiatric problems? yes no

PULMONARY

1. Have you ever had pneumonia? yes no
2. Have you ever had bronchitis? yes no
3. Have you ever had asthma? yes no

4. Have you ever had a blood clot in the lung? yes no
5. Do you have a chronic cough? yes no
6. Have you ever coughed up blood? yes no
7. Have you ever had an abnormal chest x-ray? yes no
8. Have you ever had a positive test for
tuberculosis (PPD) yes no

GASTROINTESTINAL

1. Have you ever had an ulcer? yes no
2. Do you have indigestion, heartburn or reflux? yes no
3. Do you have difficulty swallowing? yes no
4. Have you ever passed blood from the rectum? yes no
5. Any recent change in bowel habits? yes no
6. Have you ever had hepatitis or liver disease? yes no
If so, cause? _____
7. Has your weight recently changed? yes no

GENITOURINARY

1. Have you ever had kidney stones? yes no
2. Have you ever had an infection in your
Kidneys / Bladder? yes no
3. Do you have any difficulty urinating? yes no
4. Have you noticed blood in your urine? yes no
5. Do you have any history of kidney disease? yes no

MUSCULOSKELETAL

1. Do you have back pain? yes no
2. Do you have a history of arthritis? yes no
3. Do you have muscle pain, tenderness or swelling? yes no

METABOLIC

1. Do you have diabetes? yes no
Controlled with: Diet_____ Oral agents_____ Insulin _____
2. Have you ever had a thyroid problem? yes no
3. Have you ever had elevated cholesterol or triglyceride levels? yes no

HEMATOLOGIC

1. Do you have a history of a bleeding disorder? yes no
If so, what type? _____

SKIN

1. Do you have skin problems? yes no

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

Reviewed by: _____ **Date:** _____
MEDICAL HISTORY.doc