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| Patient Name: _____ | Date: _____ | Medical Record #: _____ |
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DESCRIBE YOUR REASON FOR COMING TO SEE US:

LIST PREVIOUS OPERATIONS

TYPE

DATE

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CARDIOVASCULAR HISTORY

circle appropriate response

1. Chest pain, tightness, heaviness? Y N
2. Are you short of breath with activity? Y N
3. Do you wake up at night short of breath? Y N
4. Do you need more than one pillow to sleep on? Y N
5. Do your legs and ankles swell? Y N
6. Heart skips beats or pounds/beats too fast? Y N
7. Pain in the legs/buttocks while walking? Y N
How far can you walk before onset of pain? _____ Blocks _____ Feet
8. Heart attack? When _____ Y N
9. Heart Catheterization? When _____ Y N
10. Heart surgery or balloon procedure? Y N
Date _____ Type _____
11. Echocardiogram? (ultrasound of the heart) Y N
12. Blood clots in the legs/lungs? Y N
13. Varicose veins? Y N
14. Black-out spells? Y N
15. Dizziness/Lightheadedness? Y N
16. Rheumatic fever? Y N
17. Heart murmur? Y N

CARDIAC/VASCULAR RISK FACTORS

circle appropriate response

1. Have you ever smoked/chewed tobacco? Y N
pack/day _____ years smoked _____ year quit _____
2. Do you have high blood pressure? Y N
How long has this been treated? _____
3. Do you have high blood cholesterol? Y N
4. Are you diabetic? Y N
5. Is there a family history of: Please list relationship
 - a. Heart disease Y N _____
 - b. Diabetes Y N _____
 - c. Cancer Y N _____
 - d. Stroke Y N _____
 - e. Abdominal aortic aneurysm Y N _____
 - f. Peripheral arterial disease Y N _____
 - g. Carotid disease Y N _____
 - h. Aortic dissection Y N _____
 - i. High blood pressure Y N _____

HABITS/SOCIAL HISTORY

circle appropriate response

1. Do you follow a special diet? Y N
2. Do you use caffeine? Y N
Amount/day _____
3. Do you use alcohol? Y N
Amount/day _____
4. Have you a history of drug use/addiction? Y N
5. Occupation _____ Marital Status _____

SLEEP

1. Do you snore? Y N
2. Have you been told you stop breathing at night? Y N
3. Do you wake up frequently at night? Y N
4. Do you fall asleep during the day or take naps? Y N
5. Do you feel fatigued during the day? Y N
6. Do you wake in the morning feeling tired? Y N
7. Do you wake up abruptly at night? Y N

REVIEW OF SYSTEMS

circle appropriate response

1. GENERAL

- a. Tires easily? First noticed _____ Y N
- b. Recent fevers, chills or sweats? Y N
- c. Skin rashes? Y N
- d. Recent weight loss/gain? Y N

2. EYES

- a. Blurry vision? Y N
- b. Glaucoma? Y N
- c. Partial or total loss of vision? Y N
- d. Cataracts? Y N

3. THROAT AND MOUTH

Problems with nose, teeth, sinus, mouth, throat, ears, hearing?

Circle which one(s)

Describe _____

4. LUNGS

- a. Asthma or wheezing? Y N
- b. Emphysema or bronchitis? Y N
- c. Chronic cough? Y N
- d. Bloody sputum? Y N

5. GASTROINTESTINAL

- a. Heartburn/acid reflux? Y N
- b. Difficulty swallowing? Y N
- c. Hiatal hernia? Y N
- d. Ulcer problems? Y N
- e. Black or bloody stools? Y N
- f. Gallbladder or liver problems? Y N
- g. Recent change in bowel habits? Y N

6. GENITOURINARY

- a. Blood in urine? Y N
- b. Problems with urination? Y N
- c. Urinary infections? Y N
- d. Kidney/Bladder stones? Y N
- e. Kidney Failure/Dialysis? Y N
- f. Nighttime urination? How often _____ Y N
- g. Impotence? Y N
- h. Menopause? Y N

7. MUSCULOSKELETAL

- a. Arthritis? Y N
- b. Gout? Y N
- c. Muscle or joint pains? Y N

8. ENDOCRINE

- a. Thyroid problems? Y N

9. HEMATOLOGY/LYMPHATIC

- a. Anemia? Y N
- b. Bruise/bleed easily? Y N
- c. Cancer? Type _____ Y N

10. NEUROLOGIC

- a. Chronic headaches? Y N
- b. Stroke? Y N
- c. Seizure disorder? Y N
- d. Numbness/tingling? Y N

11. PSYCHIATRIC

- a. History of mental illness? Y N
- b. Problems with depression? Y N
- c. Anxiety Problems? Y N