McLaren Cardiothoracic and Vascular
PATIENT HISTORY FORM

Please complete this form and bring it with you to your appointment

Appointment Date _____ **Appointment Time**_____

Name_____ **Referring Physician**_____

Date of Birth _____

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing

PRESENTING CIRCUMSTANCE

DESCRIBE YOUR PRESENT MEDICAL SYMPTOMS (CHIEF COMPLAINT)

Why are you here? _____

_____

_____

_____

_____

PAST MEDICAL/SURGICAL HISTORY:

DO YOU HAVE ANY ONGOING ILLNESSES OR PAST MEDICAL CONDITIONS SUCH AS:

	YES	NO		YES	NO		YES	NO
Asthma	☐	☐	Thyroid Underactive (Hypo)	☐	☐	Angina/Chest Pain	☐	☐
Bronchitis	☐	☐	Thyroid Overactive (Hyper)	☐	☐	Atrial Fibrillation	☐	☐
Cancer (Where?)	☐	☐	Peripheral Vascular Disease	☐	☐	Heart Attack (MI)	☐	☐
			Kidney Failure	☐	☐	Pain in legs with activity	☐	☐
COPD/ Emphysema	☐	☐	Rheumatic Fever	☐	☐	Hepatitis – A, B, or C.	☐	☐
Stomach Ulcers	☐	☐	Seizures	☐	☐	Stroke/CVA/TIA	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐
Insulin	☐	☐	Low Blood Pressure	☐	☐	Bleeding Problems	☐	☐
Sleep Apnea	☐	☐				High Cholesterol	☐	☐
Other _____								

ILLNESSES	Problem / Date of onset	Problem / Date of onset
Other Medical Conditions		
Other Cardiac Conditions		
Other Infectious Diseases I have had		
	☐ **Chicken Pox** ☐ **Measles** ☐ **Mumps**	
Trauma (broken bones or major injuries)?	**Please list:**	
SURGERIES	**Procedure / Date**	**Procedure / Date**

(Heart Procedures) Cardiology Invasive		
(Arterial, Vein Procedures) Peripheral Vascular		

ALLERGY

DO YOU HAVE ANY ALLERGIES TO DRUGS OR FOOD: ☐ **YES** ☐ **NO**

Allergy To and Reaction		Allergy To and Reaction	

MEDICATION

- **Please list your medications here or bring a separate list indicating each medication by name, how much you take (dosage), how often you take it (once a day or more?), and who prescribed it.**

List all Medications:

Medication Name	Dosage	How often taken?	Who Prescribed?

FAMILY MEDICAL HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers				
Sisters				

Any other family history of cardiovascular disease, strokes, diabetes or cancer? Please explain:

_____

_____

SOCIAL HISTORY AND LIFESTYLE:

How many alcoholic beverages (☐ beer, ☐ wine, or ☐ liquor) do you drink on an average day? _____

Do you currently smoke ☐ Yes ☐ No If yes, what do you smoke? ☐ cigarette ☐ cigar ☐ pipe ☐ chewing tobacco.

How long have you been smoking? _____ If you quit smoking, when did you quit? _____

How many packs per day do or did you smoke? _____

Are you on a special diet? ☐ Yes ☐ No If yes, what type of diet? _____

How many cups of caffeinated beverages do you drink on an average day?_____

Do you exercise on a regular basis? ☐ Yes ☐ No If yes, what kind of exercise?_____

Do you have a history of drug dependency? ☐ Yes ☐ No If yes, specify _____

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many children do you have?_____

What was the highest grade of formal education that you finished? _____

Current or previous occupation_____ Retired: ☐ Yes ☐ No

If you currently work, how many hours per week does it involve?_____

Any heavy physical exertion while working? ☐ Yes ☐ No If yes, what types of things?_____

REVIEW OF SYSTEMS

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.			
GENERAL:	**YES**	**NO**	
Change in exercise tolerance?	☐	☐	☐ Increased or ☐ Decreased
Fatigue?	☐	☐	
Weight Change? ☐ Gain or ☐ Loss How much? _____Period of time? _____	☐	☐	
Change in Appetite?	☐	☐	
INTEGUMENTARY (SKIN):	**YES**	**NO**	
Changes in moles?	☐	☐	
Rash? Location of rash:	☐	☐	
Itching? Location of itching:	☐	☐	
Changes in hair?	☐	☐	
Changes in nails?	☐	☐	
EYES:	**YES**	**NO**	
Do you wear glasses/contacts?	☐	☐	
Do you have blurred vision?	☐	☐	
Do you experience double vision?	☐	☐	
Do you have a history of cataracts?	☐	☐	
Glaucoma?	☐	☐	
Have you experienced visual field loss?	☐	☐	
Do you have macular degeneration?	☐	☐	
EARS, NOSE and THROAT:	**YES**	**NO**	
Do you have a hearing deficit?	☐	☐	
Dizziness with changing position?	☐	☐	
Chronic sinus problems?	☐	☐	
Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.			

EARS, NOSE and THROAT: (continued)	**YES**	**NO**	
Do you have nosebleeds?	☐	☐	
Do you wear dentures?	☐	☐	
Hoarseness/Change in voice?	☐	☐	
RESPIRATORY: (Lungs)	**YES**	**NO**	
Do you have a chronic cough? Is it Productive? ☐ Yes ☐ No	☐	☐	
Have you coughed up blood?	☐	☐	
Do you experience shortness of breath? ☐ At rest? or ☐ With Activity?	☐	☐	
Do you wheeze?	☐	☐	
Do you snore?	☐	☐	
CARDIOVASCULAR: (Heart)	**YES**	**NO**	
Chest ☐ pain ☐ pressure ☐ tightness or ☐ heaviness? ☐ At rest? or ☐ With activity?	☐	☐	
Heart palpitations: ☐ skipping ☐ fluttering ☐ racing	☐	☐	
Irregular heart beats?	☐	☐	
Short of breath lying flat?	☐	☐	How many pillows do you sleep on at night?
Wake up panicky and/or short of breath?	☐	☐	
Have you passed out?	☐	☐	
Swelling of feet or ankles?	☐	☐	
Pain in legs with walking?	☐	☐	Describe distance before pain develops:
Varicose veins?	☐	☐	
Non-healing sores on legs or feet?	☐	☐	
History of blood clots or phlebitis?	☐	☐	
GASTROINTESTINAL SYSTEM: (Stomach)	**YES**	**NO**	
Frequent nausea?	☐	☐	
Frequent heartburn?	☐	☐	If yes, is it before or after meals?
Frequent vomiting?	☐	☐	
Frequent diarrhea?	☐	☐	
Problems with constipation?	☐	☐	
Blood in Stool?	☐	☐	
Gallbladder problems?	☐	☐	
Liver Problems?	☐	☐	
GENITOURINARY: (Urinary)	**YES**	**NO**	
Do you have pain with urination?	☐	☐	
Blood in urine?	☐	☐	
Sense of urgency to urinate?	☐	☐	
Awaken frequently to urinate?	☐	☐	
History of ☐ bladder or ☐ kidney infection?	☐	☐	
History of kidney stones?	☐	☐	
Males: Prostate problems?	☐	☐	
Females: Post menopausal?	☐	☐	If yes, are you on hormone replacement? ☐ **Yes** ☐ **No**

GYNECOLOGICAL SYSTEM (Women Only)

Number of pregnancies?_____ Number of deliveries?_____

Date of last Pap Test?_____Was last pap test normal? ☐ **Yes** ☐ **No** Date of last menstrual period?_____

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

MUSCULOSKELETAL: (Muscle and Bone)	**YES**	**NO**	
Chronic back pain?	☐	☐	
Arthritis? ☐ Osteo or ☐ Rheumatoid	☐	☐	
History of Gout?	☐	☐	
History of blood clots in legs?	☐	☐	
History of vein ligation or stripping?	☐	☐	
Fibromyalgia?	☐	☐	
NEUROLOGICAL:	**YES**	**NO**	
Temporary ☐blurred vision or ☐loss of vision?	☐	☐	If yes, which eye ☐ **Right** ☐ **Left**
Temporary ☐numbness ☐ tingling ☐weakness of arm?	☐	☐	If yes, which arm ☐ **Right** ☐ **Left**
Temporary ☐numbness ☐ tingling ☐weakness of leg?	☐	☐	If yes, which leg ☐ **Right** ☐ **Left**
Fainting?	☐	☐	
Severe Headaches?	☐	☐	
Migraine Headaches?	☐	☐	
Convulsions/Seizures?	☐	☐	
PSYCHIATRIC: (Mental Health)	**YES**	**NO**	
Do you have a history of depression?	☐	☐	
Do you have chronic anxiety?	☐	☐	
ENDOCRINE:	**YES**	**NO**	
High Cholesterol?	☐	☐	
Diabetes?	☐	☐	
Thyroid Problems?	☐	☐	
HEMATOLOGICAL/IMMUNOLOGIC:	**YES**	**NO**	
Chronic low blood count/anemia?	☐	☐	
Bleeding problems?	☐	☐	
Seasonal Allergies?	☐	☐	
Latex Allergy?	☐	☐	
SLEEP HISTORY:	**YES**	**NO**	
Daytime sleepiness and/or excessive fatigue?	☐	☐	
Loud or irregular snoring?	☐	☐	
Been told that you hold your breath when you sleep?	☐	☐	
Wake up and find it difficult to catch your breath?	☐	☐	
Have restless sleep?	☐	☐	
Wake up with headaches on a regular basis?	☐	☐	
Do you choke at night?	☐	☐	
Extremity jerking during sleep?	☐	☐	
Wake up with acid-like taste in your mouth?	☐	☐	
Use ☐ CPAP or ☐ BIPAP	☐	☐	
Have ☐ CPAP or ☐ BIPAP but do not use?	☐	☐	