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	_____ Heart Murmur
_____ Shortness of breath	_____ Rheumatic fever
_____ Irregular heartbeat/arrhythmia	_____ Myocardial Infarction (heart attack)
_____ Fast heart beat	_____ Enlarged heart/heart failure
_____ Dizziness	_____ Coronary artery disease
_____ Passing out/syncope	_____ Blood clot in heart, lungs, or leg
_____ Swelling of feet/ankles or hands	_____ Aneurysm
_____ Leg pain when walking/claudication	_____ 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