

HEART & VASCULAR CLINIC

PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Patient Full Legal Name:

First	Middle	Last	Nickname
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Date of Birth: _____ Age: _____

Family Physician (First & Last Name): _____ Telephone: _____

Referring Physician (First & Last Name): _____ Telephone: _____

Reason for consulting Cardiologist: _____

CARDIOLOGIST'S NOTES:

WT: _____ LBS HT: _____ " RUE BP _____ LUE BP _____ HR _____ RR _____

Please circle/check off if you have any of the following:

- | | | |
|--|-----|----|
| 1. Chest discomfort | Yes | No |
| If yes, is it: | | |
| a. Tightness | Yes | No |
| b. Aching | Yes | No |
| c. Heaviness | Yes | No |
| d. Burning | Yes | No |
| e. Sharp | Yes | No |
| f. Does it go into _arm _back | Yes | No |
| g. Does it go into _neck _jaw | Yes | No |
| Is it accompanied by | | |
| 1. Nausea | Yes | No |
| 2. Sweating | Yes | No |
| 3. Weakness | Yes | No |
| 2. Shortness of breath | Yes | No |
| 3. Irregular heartbeat | Yes | No |
| 4. _Leg _foot swelling | Yes | No |
| 5. Calf discomfort with walking | Yes | No |
| 6. _Weak _fainting spells | Yes | No |
| 7. _Blind spot, _weak arm or _leg, _slurred speech | Yes | No |
| 8. Unusual cough or wheezing | Yes | No |

Past History – Medical – Check Items That Apply to You:

- | | | |
|---|---|---|
| <input type="checkbox"/> Coronary Disease (Blockage) | <input type="checkbox"/> Rheumatic or Scarlet Fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Cholesterol/lipids | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Angioplasty (Balloon, Stent, etc.) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Hepatitis (Indicate A, B, C) | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arrhythmia (Abnormal Heart Rhythm) | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> GI Bleeding | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Carotid Disease | <input type="checkbox"/> Allergies, Hay Fever | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Valve Disease | <input type="checkbox"/> Hives, Eczema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Mitral Valve Prolapse/Click | | |

List any other serious childhood or adult illness: _____

Past History – Surgical: Operations:

Approximate Date - Month & Year:

Coronary bypass or valve surgery	_____
Carotid surgery	_____
Peripheral vascular surgery	_____
Aneurysm repair or stent	_____
Coronary balloon or stent	_____
Peripheral balloon or stent	_____
Kidney or other vessel balloon or stent	_____
Pacemaker/Defibrillator	_____
Special heart or vascular tests e.g. stress, echo, angio	_____
Hysterectomy (ovaries removed ___Y ___N)	_____
Gallbladder surgery_____ Appendectomy_____	_____
Other	_____

Medications: Please list all of your (prescription and over the counter) medications and exact dosages, with times taken during the day/week/month (Please list heart/blood pressure/cholesterol related medications first)

- | | |
|-----------|-----------|
| 1. _____ | 11. _____ |
| 2. _____ | 12. _____ |
| 3. _____ | 13. _____ |
| 4. _____ | 14. _____ |
| 5. _____ | 15. _____ |
| 6. _____ | 16. _____ |
| 7. _____ | 17. _____ |
| 8. _____ | 18. _____ |
| 9. _____ | 19. _____ |
| 10. _____ | 20. _____ |

Alternative/Complementary Medicine/Herbal/Natural Supplement Usage:

Allergies: ___None Please list all allergies that you may have. This would include allergies to any medicines, contrast "dyes", foods, etc. _____

Family History: (Family member with hypertension, coronary disease, heart failure, stroke, diabetes or unexplained death – give diagnosis, approximate age at onset and at death if applicable.)

Father_____ Paternal ___Grandfather___Uncle_____

Mother_____ Paternal ___Grandmother___Aunt_____

Brothers_____ Maternal ___Grandfather___Uncle_____

Sisters_____ Maternal ___Grandmother___Aunt_____

Social History:

Marital status: ___ Married ___ Widowed ___ Divorced ___ Separated ___ Single

Your occupation: _____

Spouse occupation: _____

Children: (ages and occupations) _____

Habits:

Tobacco: ___ Never ___ Present ___ Packs per day? ___ Cigars per day? ___ Chewing? ___ Oz per day?
___ Past ___ Packs per day? Date stopped _____ ___ Total years of use

Alcohol: how much per day? ___ None ___ Beer ___ Wine ___ Liquor

Caffeinated Drinks: How many per day? Regular _____ Decaffeinated _____

Exercise ? ___ None ___ Yes Describe: _____

Please indicate whether you have experienced any of the following:

- | | | | |
|----------------------------|------------------------|--------------------------|---------------------|
| ___ Fatigue | ___ Weight loss | ___ Night sweats | ___ Cataracts |
| ___ Blurred vision | ___ Glaucoma | ___ Hearing loss | ___ Ringing in ears |
| ___ Difficulty swallowing | ___ Dry, hoarse throat | ___ Wheezing | ___ Chronic cough |
| ___ Asthma | ___ Tuberculosis | ___ Abdominal pain | ___ Blood in stool |
| ___ Ulcers | ___ Blood in urine | ___ Arthritis | ___ Back pain |
| ___ Muscle weakness | ___ Skin rash | ___ Headaches | ___ Memory loss |
| ___ Stroke | ___ Speech problems | ___ Depression/anxiety | ___ Unusual stress |
| ___ Eating disorder | ___ Thyroid problem | ___ Unexplained bruising | ___ Drug allergies |
| ___ Pollen, dust allergies | ___ Seizures | | |

NOTE: PLEASE SEE YOUR PRIMARY CARE PHYSICIAN FOR NON-CARDIAC PROBLEMS.

Patient's Signature _____ Date _____

Physician's Signature _____ Date _____