PATIENT HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Chief Complaint ______________________________

	Yes	No
Do you have pain, tightness or pressure in the front or back of your chest?	❑	❑
If yes, is it when walking fast, working hard, or when excited?	❑	❑
Have you ever been told that your electrocardiogram was abnormal?	❑	❑
Do you have swelling of your feet or ankles?	❑	❑
Does your heart ever beat fast or irregularly?	❑	❑
Do you have cramps in the calf muscles when you walk?	❑	❑
Do you ever awaken at night with severe difficulty breathing?	❑	❑
Were you ever told of heart murmur?	❑	❑

Do you have unexplained:	Yes	No
sweating?	❑	❑
fainting or near fainting spells?	❑	❑
Have you had:		
past history of cardiac catheterization?	❑	❑
by-pass surgery?	❑	❑
exercise treadmill test?	❑	❑
echocardiogram?	❑	❑
pacemaker?	❑	❑
internal defibrillator?	❑	❑

Are you allergic to IV Contrast (dye)? Yes ❑ No ❑

If yes, when / where

____
____
____
____
____
____

PAST HISTORY (Personal)

Have you had any of the following illnesses?

	Yes	No
Rheumatic Fever	❑	❑
Angina Pectoris	❑	❑
Heart Attack	❑	❑
Other Heart Disease	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑

PERSONAL HABITS

1. Check if you regularly smoke:
   ❑ Cigarettes: Pack(s) per day____ ❑ Pipe ❑ Cigars
   How long have you been smoking?______years
   If you are a former smoker, when did you quit? ____________
2. Check if you regularly drink:
   ❑ Hard Liquor: 1-3 oz. per day ❑ Over 3 oz. per day ❑
   ❑ Beer: 1 bottle per day ❑ 2 bottles ❑ 3 or more ❑
   ❑ Wine: 1 glass per day ❑ 2 glasses ❑ 3 or more ❑

Are you allergic to any medications? Yes ❑ No ❑

If yes, please list medications and the reaction you had to them:

____
____

SOCIAL HISTORY

Marital Status

❑ Single ❑ Married ❑ Separated ❑ Divorced
❑ Widowed ❑ Remarried

Whom do you live with? ____________

Do you have a regular exercise program? ❑ ❑

Please identify your hobby or hobbies:

____
____
____
____

Level of education (years):

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 >16

What type of work do you do?

Operations: Indicate approximate year and hospital.

____
____

MEDICATIONS

Please list all medications that you are currently receiving:

Medication	Dose	Yr. Started

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FAMILY HISTORY

NAME		If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brothers / Sisters	(Circle Sex) M F				
	M F				
	M F				
	M F				
	M F				
Husband / Wife					
Sons / Daughters	(Circle Sex) M F				
	M F				
	M F				
	M F				
	M F				

Check if any blood relative has or has had any of the following and enter relationship.

	Yes	No	Relationship
Stroke	❑	❑	______
Cancer	❑	❑	______
High Blood Pressure	❑	❑	______
Diabetes	❑	❑	______
Heart Attack	❑	❑	______
Kidney Disease or Dialysis	❑	❑	______

Patient's Name ______________________________

(over)

Hospitalizations (other than operations): List reasons, approximate dates and hospitals.

____

REVIEW OF SYSTEMS:

A. General	Yes	No
Do you usually feel tired or worn out?	❑	❑
Do you feel depressed a lot of the time?	❑	❑
Have you recently noticed that heat or warm weather bothers you?	❑	❑
Have you recently been drinking more water or fluids?	❑	❑
Has there been any unusual weight gain or loss recently?	❑	❑
Have you ever had cancer?	❑	❑
Have you ever had arthritis?	❑	❑
Have you ever had any of the following illnesses?		
anemia?	❑	❑
kidney disease?	❑	❑
kidney stones?	❑	❑
gout?	❑	❑
thyroid?	❑	❑
frequent kidney or bladder infections?	❑	❑
venereal disease?	❑	❑

B. Musculoskeletal	Yes	No
Do you have a problem with back pain?	❑	❑
Do you have pain in your legs or feet?	❑	❑
Does back pain interfere with your work or activities?	❑	❑
Do you have joint pain or stiffness?	❑	❑
Do you have trouble walking or using your hip or knee joints?	❑	❑

C. Central Nervous System	Yes	No
Have you ever had a stroke?	❑	❑
Do you have frequent or severe headaches?	❑	❑
Do you often have spells of dizziness or faintness or lightheadedness?	❑	❑
Have you ever seen double?	❑	❑
Do you sometimes lose track of what happens to you for a short time?	❑	❑
Do you sometimes lose the ability to speak for a few seconds?	❑	❑
Have you recently fainted, blacked out or lost consciousness?	❑	❑
Do you have trouble remembering recent events?	❑	❑
Have you ever had convulsions, fits or seizures?	❑	❑
Do you have numbness or tingling in your head, arms or legs?	❑	❑
Do you consider yourself to be a nervous person?	❑	❑

D. Gastrointestinal	Yes	No
Have you recently had any change in your eating habits?	❑	❑

Gastrointestinal (Cont.)	Yes	No
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc.?	❑	❑
Do you tend to burp a lot?	❑	❑
Have you recently noted any trouble swallowing?	❑	❑
Do you have a lot of indigestion or heartburn?	❑	❑
Have you ever vomited blood?	❑	❑
Are you bothered with constipation?	❑	❑
Do you have frequent loose stools or diarrhea?	❑	❑
Do you pass a lot of gas?	❑	❑
Do you have a poor appetite?	❑	❑
Do you ever awaken at night with the feeling of fullness underneath your breastbone?	❑	❑
Have you ever passed blood from your rectum?	❑	❑
Have you ever had black or tarry stools?	❑	❑
Have you noticed any recent changes in your bowel movements?	❑	❑
Do you take laxatives regularly?	❑	❑
Do you have frequent nausea and/or vomiting?	❑	❑
Do you have stomach ulcers?	❑	❑
Have you ever had:		
stomach ulcers?	❑	❑
gallbladder disease?	❑	❑
yellow jaundice?	❑	❑
hepatitis?	❑	❑
colitis?	❑	❑

E. Respiratory	Yes	No
Have you ever had:		
pneumonia?	❑	❑
bronchitis?	❑	❑
Do you have:		
frequent chest colds?	❑	❑
a constant or bothersome cough?	❑	❑
coughing of blood?	❑	❑
sputum or phlegm between colds?	❑	❑
difficulty breathing?	❑	❑
Have you noticed any wheezing or whistling in your chest?	❑	❑
Can you walk on level ground without stopping to catch your breath?	❑	❑
Have you ever had asthma?	❑	❑

F. Women Only	Yes	No
Have you had menopause or the change of life?	❑	❑

If not, last menstrual period?______________________

Method of birth control: _________________________

G. Men Only	Yes	No
Have you had problems with impotence?	❑	❑