

PATIENT HISTORY FORM

Appointment Date _____ Name _____

Appointment Time _____ Referring Physician _____

Date of Birth _____ Social Security # _____ / _____ / _____

PHYSICIANS List all doctors providing care

Doctor's Name	Type of Doctor <i>Primary Care, Urologist, etc</i>	Reason for seeing this doctor
	Primary Care Doctor	

ALLERGIES Do you have allergies to drugs, food, latex, dye? YES NO

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc

CURRENT MEDICATIONS List all vitamins, prescription medications, and over-the-counter medications.

♥ **BRING all medications in their original containers to your appointment!**

Medication Name	Dosage	How often do you take?	Prescribing Physician

REVIEW OF SYSTEMS

Circle if you are experiencing symptoms or check "No Symptoms"

General

- No Symptoms
- Recent Fever
 - Chills
 - Night Sweats
 - Recent weight loss/gain
 - Loss of energy

Integumentary (Skin)

- No Symptoms
- Rashes
 - Changes in mole
 - Changes in hair or nails
 - Discharge from nipples
 - Breast lumps
 - Breast biopsy

Eyes

- No Symptoms
- Blind spots
 - Double vision
 - Recent change in vision

Ears, Nose, and Throat

- No Symptoms
- Recent Hearing loss
 - Ringing in ears
 - Sore throat
 - Difficulty swallowing
 - Nasal Congestion
 - Nose bleeds

Respiratory

- No Symptoms
- Recent Cough
 - Wheezing
 - Pain when breathing
 - Excessive sputum

Cardiovascular

- No Symptoms
- Chest pain
 - Shortness of Breath
 - Leg Swelling
 - Heart murmur
 - Palpitations
 - Phlebitis

Abdominal

- No Symptoms
- Nausea
 - Vomiting
 - Diarrhea
 - Constipation
 - Abdominal pain/cramping
 - Blood in stools

Genitourinary

- No Symptoms
- Burning on urination
 - Bloody urine
 - Difficulty urinating
 - Urination at night:
of times _____
 - Difficulty with erections

Musculoskeletal

- No Symptoms
- Unusual muscle aches
 - Arthritis
 - Back problems

Neurological

- No Symptoms
- Headaches
 - Dizziness
 - Stroke
 - Weakness
 - Numbness

Psychiatric

- No Symptoms
- Depression
 - Anxiety
 - Substance Abuse
 - Change in cognitive function

Endocrine

- No Symptoms
- Unexplained changes in weight
 - Goiter
 - Excessive thirst
 - Increased urination

Hematological

- No Symptoms
- Excessive Bleeding
 - Easy bruising

PAST MEDICAL HISTORY

Circle past history

Past Illnesses

- Asthma
- Bronchitis/Emphysema
- Cancer
- Diabetes
- Kidney stones/kidney failure
- Liver/Gallbladder
- Peptic Ulcer - GERD
- Prostate
- Rheumatic Fever
- Seizures
- Sleep Apnea
- Stroke/CVA
- Thyroid Disease

Other _____

Infectious Disease History

Trauma History

Past Cardiac Illnesses

- Angina/Chest Pain
- Atrial Fibrillation
- Congestive heart failure (CHF)
- Coronary artery disease
- Heart Attack (MI)
- High Blood Pressure
- High Cholesterol
- Irregular heartbeat (arrhythmias)
- Peripheral Vascular Disease
- Valvular heart disease

Other _____

Past Surgeries/Procedures

- Appendectomy
- Back
- Breast
- Cataract
- Gallbladder
- Hernia – Hiatal/Inguinal
- Hip
- Hysterectomy
- Intestinal
- Knee
- Prostate
- Tonsils/Adenoids

Other _____

Past Cardiac Surgery/Procedures

- Cardiac Cath
- Cardioversion
- Coronary angioplasty / Stent
- Coronary artery bypass
- EP Study
- ICD
- Pacemaker implant
- RF ablation

SOCIAL HISTORY AND LIFESTYLE

<p>Alcohol Use Yes No Do you consume alcohol? Average number per day ___ beer ___ wine ___ liquor</p> <p>Smoking/Tobacco Use Yes No Do you smoke or use tobacco? Yes No Have you smoked in the past? Number of years? ___ Packs per day _____</p> <p>Diet Yes No Are you on a special diet? What type of diet? _____ Yes No Do you drink caffeinated beverages? (coffee, tea, cola, etc) How many daily? _____</p> <p>Exercise Yes No Do you exercise on a regular basis? Minimum of 30 minutes / 3 times a week</p> <p>Substance Abuse Yes No Do you have a history of drug dependency? If yes, specify: _____</p>	<p>Lifestyle <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed</p> <p>Occupation _____ <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed</p> <p>Residence <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with children <input type="checkbox"/> Lives with parents <input type="checkbox"/> Lives with spouse <input type="checkbox"/> Lives with spouse/children <input type="checkbox"/> Lives with male partner <input type="checkbox"/> Lives with female partner <input type="checkbox"/> Nursing home resident <input type="checkbox"/> Assisted living resident</p> <p>What do you like to do (hobbies)? _____ _____ _____</p>
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FAMILY MEDICAL HISTORY

<p style="text-align: center;">Family Cardiac History</p> <p>Father</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Alive</td> <td><input type="checkbox"/> Heart attack before age 60</td> </tr> <tr> <td><input type="checkbox"/> Deceased at age _____</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sudden cardiac death</td> </tr> </table> <p>Mother</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Alive</td> <td><input type="checkbox"/> Heart attack before age 60</td> </tr> <tr> <td><input type="checkbox"/> Deceased at age _____</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sudden cardiac death</td> </tr> </table> <p>Sibling(s)</p> <p>_____ Number of Brother(s)</p> <table style="width: 100%;"> <tr> <td># _____ Alive</td> <td><input type="checkbox"/> Heart attack before age 60</td> </tr> <tr> <td># _____ Deceased at age(s) _____</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sudden cardiac death</td> </tr> </table> <p>_____ Number of Sister(s)</p> <table style="width: 100%;"> <tr> <td># _____ Alive</td> <td><input type="checkbox"/> Heart attack before age 60</td> </tr> <tr> <td># _____ Deceased at age(s) _____</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sudden cardiac death</td> </tr> </table>	<input type="checkbox"/> Alive	<input type="checkbox"/> Heart attack before age 60	<input type="checkbox"/> Deceased at age _____	<input type="checkbox"/> Stroke		<input type="checkbox"/> Sudden cardiac death	<input type="checkbox"/> Alive	<input type="checkbox"/> Heart attack before age 60	<input type="checkbox"/> Deceased at age _____	<input type="checkbox"/> Stroke		<input type="checkbox"/> Sudden cardiac death	# _____ Alive	<input type="checkbox"/> Heart attack before age 60	# _____ Deceased at age(s) _____	<input type="checkbox"/> Stroke		<input type="checkbox"/> Sudden cardiac death	# _____ Alive	<input type="checkbox"/> Heart attack before age 60	# _____ Deceased at age(s) _____	<input type="checkbox"/> Stroke		<input type="checkbox"/> Sudden cardiac death	<p>Personal Cardiac Risk Factors</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of tobacco use <input type="checkbox"/> Family history heart disease (immediate family) <input type="checkbox"/> History high cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> History of diabetes <input type="checkbox"/> Prior history of heart disease <input type="checkbox"/> History of obesity <input type="checkbox"/> Sedentary lifestyle <input type="checkbox"/> Age (Male over 45 - Female over 55) <input type="checkbox"/> Menopausal female
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