Coastal Cardiology Medical History

Name____ Date__________________________

DOB______________ Age_________________

Referring Physician ____

Reason for Visit ____

Height________ Weight________ P________ R________ B/P________

Have you ever had any of the following?

Cancer	Yes	No	Stroke	Yes	No
Heart problems	Yes	No	Eye disease	Yes	No
Weight loss	Yes	No	Nervous Disorder	Yes	No
Speech/Hearing problems	Yes	No	Asthma/Emphysema	Yes	No
Anemia	Yes	No	Tuberculosis	Yes	No
Seizures	Yes	No	Night Sweats	Yes	No
Infectious Diseases	Yes	No	Coughing blood	Yes	No
Arthritis	Yes	No	Difficulty swallowing	Yes	No
Kidney problems	Yes	No	Foot or leg ulcers	Yes	No
Are you pregnant?	Yes	No	Poor circulation	Yes	No
Other problems?	Yes	No	Bleeding Problems	Yes	No

Do you have any of the following?

Recent weight loss	Yes	No	Leg pain with walking	Yes	No
Chills	Yes	No	Wheezing	Yes	No
Night Sweats	Yes	No	Cough	Yes	No
Generalized weakness	Yes	No	Bloody cough	Yes	No
Blurry vision	Yes	No	Constipation	Yes	No
Double vision	Yes	No	Diarrhea	Yes	No
Hearing loss	Yes	No	Black/tarry stools	Yes	No
Vertigo	Yes	No	Bloody stools	Yes	No
Lightheadedness	Yes	No	Painful urination	Yes	No
Dizziness	Yes	No	Incontinence	Yes	No
Nose bleeds	Yes	No	Bloody urine	Yes	No
Sore throat	Yes	No	Rashes	Yes	No
Hoarse voice	Yes	No	Itches	Yes	No
Chest pressure or pain	Yes	No	Passing out	Yes	No
Skipping heart	Yes	No	One sided weakness	Yes	No
Shortness of breath	Yes	No	Numbness	Yes	No
Short of breath lying flat	Yes	No	Tingling	Yes	No
Wake up breathless	Yes	No	Excessive urination	Yes	No
Swelling of ankles	Yes	No	Excessive thirst	Yes	No

Social History

Do you smoke? _____Yes _____No _____Former If Yes, how much? ______When did you quit? _____

Do you use any illicit drugs? ____No ____Yes ____Occasionally

Do you drink alcohol? ____No ____ Rarely ____Socially ____Quit _____Frequently, ____drinks a day

Do you drink coffee? ____No ____Yes ______cups per day

Do you drink tea? ____No ____Yes ______cups per day

What type of work do you do? ____

Interests: ____

Do you use any aids such as a walker, cane, wheelchair, hearing aid, etc.?

____

Do you have any language or learning barriers we need to know about?

____

Marital status: ____ Married ____ Single ____ Widow ____ Divorced ____ In a relationship

Children: ____ none ____son(s) ____ daughter(s)
Ages: ____________________________________

Exercise: ___ None ___ Regular ___Occasionally ___ 3x a week or more

Type of exercise: ____

Describe your daily eating habits: ____
____

Family History

Please mark all that apply.

______ There is no family history of heart disease or vascular disease.

Father: ____ Alive ____ Deceased Age deceased: _____
Known Conditions: ____ High Cholesterol ____ High Blood Pressure ____ Coronary Artery Disease
____Coronary Artery Bypass Surgery ____ Heart Attack ____ Stroke ____ Other____________________

Mother: ____ Alive ____ Deceased Age deceased: _____
Known Conditions: ____ High Cholesterol ____ High Blood Pressure ____ Coronary Artery Disease
____Coronary Artery Bypass Surgery ____ Heart Attack ____ Stroke ____ Other____________________

Brother: ____ Alive ____ Deceased Age deceased: _____
Known Conditions: ____ High Cholesterol ____ High Blood Pressure ____ Coronary Artery Disease
____Coronary Artery Bypass Surgery ____ Heart Attack ____ Stroke ____ Other____________________

Sister: ____ Alive ____ Deceased Age deceased: _____
Known Conditions: ____ High Cholesterol ____ High Blood Pressure ____ Coronary Artery Disease
____Coronary Artery Bypass Surgery ____ Heart Attack ____ Stroke ____ Other____________________

<u>If you have chest pain please answer the following:</u>

Character: ___Sharp ___Dull ___Burning ___Tightening ___Other

Duration: ___less than 10 seconds ___10 seconds to 1 minute ___1 minute to 15 minutes

___15 minutes to 60 minutes ___greater than 60 minutes

Provoked by: ___eating large meals ___exertion ___stress or anxiety

___lying flat ___pressing on the chest wall ___other

Relieved by: ___rest ___walking around ___taking nitroglycerin ___eating

___ taking antacids ___ rubbing on chest wall ___burping ___other

Associated symptoms: (things that occur at the same time you experience chest pain)

___shortness of breath ___ palpitations ___sweatiness ___nausea

___burping ___weakness ___passing out ___jaw pain ___ arm pain

Risk factors: Circle all that apply

Diabetes Elevated Cholesterol High Blood Pressure Family History of Heart Disease

Miscellaneous

Have you seen a cardiologist previously? ____ yes ____ no
If yes, who? ________________________________ When? __________________________

Have you ever had heart surgery? ____ yes ____ no
If yes, who? ________________________________ When? __________________________

Have you ever had a heart catheterization? ____ yes ____ no
If yes, who? ________________________________ When? __________________________

Have you ever been told you have a heart murmur? ____ yes ____ no
If yes, who? ________________________________ When? __________________________

Current Medications

Name	Strength	Times per Day

Please list all known medication allergies: