CARDIOVASCULAR SOLUTIONS

HEALTH HISTORY

Date:_____

Name:_____DOB:_____

Referring Doctor:_____ Primary Doctor:_____

Why are you seeing a cardiologist? _____

History and Physical – Please (X)

Heart problems or symptoms:

- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Abnormal Rhythm (arrhythmia)
- ☐ Palpitations, irregular heartbeats
- ☐ Fainting
- ☐ Enlarged Heart
- ☐ Chest Pains or Pressure
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Swollen Legs
- ☐ Heart Failure
- ☐ Blue Lips or Fingernails
- ☐ Leg Cramps when you walk

Have you ever had:

- ☐ Stress Test (Treadmill)
- ☐ Echocardiogram
- ☐ Cardiac Catheterization
- ☐ Coronary Angioplasty (balloon)
- ☐ Coronary Bypass Surgery
- ☐ Valve Surgery
- ☐ Electrophysiology Study/Proc.
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ EKG
- ☐ 24 Holter Monitor
- ☐ 30 Day Event Recorder

Check if you have:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Ever Smoked
- ☐ Diabetes
- ☐ Do you exercise (walking)

Close family member with:

- ☐ Heart Attack
- ☐ Mother ☐ Father

If a Woman have you:

- ☐ Passed Menopause
  if so what age: ____
- ☐ Take Estrogen replacement

Please tell us anything else about your heart: _____

Current Medications:

(Include over-the-counter medications)

Name of Medication	Strength	Times per Day

Allergies:

Are you allergic to any medications? ☐ Yes ☐ No

List medications to which you are allergic: _____

What kind of reaction did you have? _____

Past Medical History – Please (X) any symptoms you have or have had in the past year.

Constitutional

- ☐ Lack of energy
- ☐ Trouble sleeping
- ☐ Loss of Appetite
- ☐ Weight changes
- ☐ Fever

HEENT

- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Buzzing or ringing in ears
- ☐ Hay fever
- ☐ Sinus Problem

Respiratory

- ☐ Wheezing
- ☐ Cough
- ☐ Coughing blood
- ☐ Asthma
- ☐ Tuberculosis

OVER >>

HEALTH HISTORY Continued:
Name: _____

Digestive
- ☐ Indigestion
- ☐ Change in bowel habits
- ☐ Bloody or tarry stools
- ☐ Jaundice
- ☐ Liver problems
- ☐ Ulcers Gallstones

Dermatological
- ☐ Rash
- ☐ Itching
- ☐ Other skin problems

Neurological
- ☐ Paralysis (even temporary)
- ☐ Stroke
- ☐ Numbness
- ☐ Loss of balance
- ☐ Dizziness

Hematological
- ☐ Bleeding
- ☐ Easy bruising

- ☐ Risk Factors for HIV
- ☐ Anemia
- ☐ Cancer

Urinary
- ☐ Frequency
- ☐ Infections
- ☐ Stones
- ☐ Bladder incontinence

Men
- ☐ Prostate problems
- ☐ Night-time urination

Women
- ☐ Abnormal Menstrual Periods
- ☐ Could you be pregnant?

Psychiatric
- ☐ Unusual thoughts
- ☐ Nervousness
- ☐ Crying or sadness
- ☐ Depression
- ☐ Suicide attempts

Musculoskeletal
- ☐ Joint pain, swelling or redness
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscle aches
- ☐ Muscle tenderness
- ☐ Gout

Female Reproductive
- ☐ Breast lumps Recent
- ☐ Mammogram
- ☐ Pap Smear &/or Pelvic Exam

Endocrinology
- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ Excess thirst
- ☐ Excess hunger
- ☐ Excess urination

Have you had any operations?
Please include dates.
1) _____ 2) _____
3) _____ 4) _____

Are you being treated now or have been treated for any illness?
1) _____ 2) _____
3) _____ 4) _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
With whom do you live? _____
Occupation _____
Leisure Activities _____
_____
Education Level _____

Health Habits:
Do you smoke? ☐ Yes ☐ No
How many packs per day? _____
For how many years? _____
How much alcohol do you drink? _____
Do you use any drugs? _____

Family History:

Check if any close family members (parents, brothers and sisters, children) have:

☐ Heart Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child

Are there any other health problems in your family? _____

Hospitalizations:

Year	Hospital	Reason