

CARDIOVASCULAR HISTORY

DATE: _____

NAME: _____

AGE: _____

SEX: _____

1. CHIEF COMPLAINT: (What is the major symptom or problem that brought you to the office? Date of onset?)

2. When did symptoms first start? _____
3. Where does the pain/symptoms start? _____
4. How long did the 1st episode last? _____
5. On a scale of 1 to 10 (with 10 being the worst), what level would you say your pain/symptom is? _____

6. Does the pain spread around or travel straight through? _____
7. How long does symptom last? _____
8. What is the timing of the symptom? (Ex. Sudden onset, gradual onset, night, morning, upon waking, during day, while sleeping, stress, etc.) _____
9. Does anything in particular bring the symptom on? (Ex: exercise, emotions, eating, sleep, sex, etc.)

10. Aggravating factors: _____
11. What gives relief? _____
12. When the symptom occurs, are there any other symptoms at the same time? (Ex: nausea, vomiting, shortness of breath, palpitations, faintness, numbness, etc?) _____
13. Have you ever seen a Cardiologist before? _____
If so, what was the Cardiologist's name and address? _____

14. Have you ever been diagnosed with a heart condition at ANY time in the past? _____
15. Do you have pain in legs when walking? _____

PAST MEDICAL HISTORY

(Please list any problems you may have had in the past)

HEENT: (Head, eyes, ears, nose, throat) _____

RESPIRATORY: (Chronic Lung disease, pneumonia, etc.) _____

BREASTS: _____

HEART: _____

a. Stroke _____ c. Thrombophlebitis _____

b. Heart murmur _____ d. Congestive Heart Failure _____

BONE & JOINT: _____

SKIN: _____

NEUROLOGICAL: _____

PSYCHIATRY: _____

ENDOCRINE: _____

VASCULAR: _____

GASTROINTESTINAL: _____

GENITOURINARY: _____

HEMATOLOGY: (Anemia, blood disorders, etc.) _____

Have you ever been diagnosed as having **HIGH CHOLESTEROL?** _____

Have you ever been diagnosed as having **DIABETES?** _____

Have you ever been diagnosed as having **HYPERTENSION?** _____

Have you ever been diagnosed as having **RHEUMATIC FEVER?** _____

Patient Name: _____ DOB: _____

FAMILY HISTORY

Please fill in each category (Age, Living/Deceased) of mother, father, brothers, sisters, etc.

IF LIVING

IF DECEASED

	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters (Circle Sex)					
	M F				
	M F				
	M F				
	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				
	M F				

SOCIAL HISTORY

1. Do you Smoke? ____ Yes ____ No Packs per day ____ No. of Years ____
Discontinued smoking ____ Yes ____ No How Long Ago? _____

2. Alcohol Intake? _____ Never _____ Occasionally _____ Socially
_____ Beer _____ Wine _____ Other

How often? _____ Daily _____ Weekly _____ Monthly

3. Diet: No Particular diet _____ Low Fat/Low Cholesterol _____
Moderate Fatty Diet _____ High fatty diet _____ Diabetic Diet _____

4. Lifestyle: _____ Single _____ Married _____ Widowed _____ Divorced _____ Other

5. Exercise: (walking, running, weights, working out in gym, etc.) _____
Frequency _____ How many times a week _____ How many times a month _____

6. Average amount of Sleep per night: (hours) _____

7. Education: High School Education _____ College _____ Degree _____

8. Occupation: _____

9. Spouse's Occupation: _____