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 wakening, 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?** _____

Do you have any known **DRUG ALLERGIES?** _____ Yes _____ No

If yes, please list drug name and the type of reaction it causes: _____

_____

_____

_____

_____

PAST SURGICAL HISTORY

Please list ALL past surgeries: (Including DATE, HOSPITAL & SURGEON who performed surgery, including ANY PRIOR HEART SURGERY)

Type of Surgery	Hospital/Doctor	Date

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				

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke _____	Epilepsy _____	Heart Attack _____	Nervous Breakdown _____
Cancer _____	Suicide _____	Stomach Ulcers _____	Rheumatic Fever _____
High Blood Pressure _____	Migraine _____	Kidney Disease _____	Insanity _____
Diabetes _____	Asthma _____	Goiter _____	Congenital Heart _____
Leukemia _____			
	Hayfever _____	Arthritis _____	
Tuberculosis_____	Bleeding Tendency _____	Colitis _____	

CURRENT MEDICATIONS

(Please list ALL medicines currently taking: aspirin, vitamins, over-the-counter, herbal, etc.)

Name of Drug	Strength	Instructions	Prescribing Physician

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: _____