

HEALTH HISTORY

Welcome to Consulting Cardiologists. As a new patient, please fill out the information below as completely as possible.

Patient Name _____ D.O.B: _____ Date: _____

Reason For Your Appointment Today: _____

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Pneumonia	No	Yes	Rheumatic Fever	No	Yes	Heart Disease	No	Yes	Arthritis	No	Yes
Anemia	No	Yes	Diabetes	No	Yes	Cancer	No	Yes	Glaucoma	No	Yes
High Blood Pressure	No	Yes	Low Blood Pressure	No	Yes	Asthma	No	Yes	Hives or Eczma	No	Yes
Bronchitis	No	Yes	Mitral Valve Prolapse	No	Yes	Stroke/TIA	No	Yes	Ulcer	No	Yes
Kidney Disease	No	Yes	Thyroid Disease	No	Yes	Bleeding Tendency	No	Yes	Any other disease(s): _____ _____		

Who Are Your Doctors?

NAME	SPECIALTY	CITY/STATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____

PLEASE BRING ALL OF YOUR CURRENT MEDICATIONS WITH YOU TO YOUR APPOINTMENT

Patient Social History:

Marital Status: Single:____ Married: ____ Separated: ____ Divorced: ____ Widowed: ____

Use of Alcohol: Never:____ Rarely: ____ Sometimes:____ Frequently:____
 (# = number of drinks) #/month: ____ #/week: ____ #/day: ____

Use of Tobacco: Never:____ Previously, but quit: ____ months/years ago Current packs/day: ____

Use of Drugs: Never:____ Type/Frequency: _____

Occupation: _____ **Regular Exercise Program:** YES or NO **Hobbies:** _____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems: Please indicate any personal history below:

<input type="checkbox"/> Constitutional Symptoms Good nutritional health lately Recent weight gain Recent weight loss Fever Fatigue	Yes No Yes No Yes No Yes No Yes No	<input type="checkbox"/> Cardiovascular Heart trouble Chest pain Chest discomfort Palpitation Shortness of breath w/walking Shortness of breath w/lying down Faint/Pass out for no reason Swelling of feet, ankles, or hands	Yes No Yes No Yes No Yes No Yes No Yes No Yes No
<input type="checkbox"/> Eyes/Ears/Nose/Mouth/Throat Blurred or double vision Hearing loss or ringing Nose bleeds Mouth sores Bleeding gums	Yes No Yes No Yes No Yes No Yes No	<input type="checkbox"/> Integumentary (skin, breast) Rash or itching Varicose veins	Yes No Yes No
<input type="checkbox"/> Hematologic/Lymphatic Bleeding/Bruising tendency Anemia Phlebitis	Yes No Yes No Yes No	<input type="checkbox"/> Respiratory Chronic or frequent coughs Spitting up blood Wheezing	Yes No Yes No Yes No
<input type="checkbox"/> Genitourinary Frequent urination Blood in urine Female-# of pregnancies _____ Female-heart problems w/pregnancy Female-have you experienced menopause	Yes No Yes No Yes No Yes No Yes No	<input type="checkbox"/> Gastrointestinal Loss of appetite Nausea or vomiting Rectal bleeding or blood in stool Abdominal pain	Yes No Yes No Yes No Yes No
<input type="checkbox"/> Psychiatric Memory loss or confusion Nervousness Depression Insomnia	Yes No Yes No Yes No Yes No	<input type="checkbox"/> Neurological Light-headed or dizzy Convulsions or seizures Numbness/tingling sensations	Yes No Yes No Yes No
<input type="checkbox"/> Musculoskeletal Weakness of muscles/joints Muscle pain or cramps Cold extremities Difficulty in walking	Yes No Yes No Yes No Yes No	<input type="checkbox"/> Other drugs/medications: _____ _____	Yes No Yes No
<input type="checkbox"/> Endocrine Glandular/hormone problem Excessive thirst or urination Heat or cold intolerance High blood sugar	Yes No Yes No Yes No Yes No	<input type="checkbox"/> Known food allergies: _____ _____	Yes No Yes No
		<input type="checkbox"/> Environmental allergies: _____ _____	Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. This information is part of my health record and is only released outside of this practice under special circumstances and/or as needed to provide for my healthcare.

Signature of Patient, Parent or Guardian

Date

Doctor's Review:

Signature of Doctor

Date