SOUTHERN OREGON
Cardiology

PATIENT HISTORY FORM

Appointment Date ____________________ Name ____

Appointment Time ____________________ Referring Physician _______________________________

Date of Birth ________________________ Social Security Number _________ /_________ /______________

PHYSICIANS **List all doctors providing care**

Doctor's Name	Type of Doctor *Primary Care, Urologist, etc.*	Reason for seeing this doctor
	Primary Care Doctor	

ALLERGIES **Do you have allergies to drugs, food, latex, dye?** ☐ **Yes** ☐ **No**

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc.

CURRENT MEDICATIONS **List all vitamins, prescription medications, and over-the-counter medications**

♥ BRING all medications in their original containers to your appointment!

Medication Name	Dosage	How often do you take?	Prescribing Physician

REVIEW OF SYSTEMS

Circle if you are experiencing symptoms or check *"No Symptoms"*

General
- ☐ *No Symptoms*
- Recent fever
- Chills
- Night sweats
- Recent weight loss/gain
- Loss of energy

Integumentary (Skin)
- ☐ *No Symptoms*
- Rashes
- Changes in mole
- Changes in hair or nails
- Discharge from nipples
- Breast lumps
- Breast biopsy

Eyes
- ☐ *No Symptoms*
- Blind spots
- Double vision
- Recent change in vision

Ears, Nose and Throat
- ☐ *No Symptoms*
- Recent Hearing loss
- Ringing in ears
- Sore throat
- Difficulty swallowing
- Nasal Congestion
- Nose bleeds

Respiratory
- ☐ *No Symptoms*
- Recent Cough
- Wheezing
- Pain when breathing
- Excessive Sputum

Cardiovascular
- ☐ *No Symptoms*
- Chest pain
- Shortness of breath
- Leg swelling
- Heart murmur
- Palpitations
- Phlebitis

Abdominal
- ☐ *No Symptoms*
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain/cramping
- Blood in stools

Genitourinary
- ☐ *No Symptoms*
- Burning on urination
- Bloody urine
- Difficulty urinating
- Urination at night: # of times_____
- Difficulty with erections

Musculoskeletal
- ☐ *No Symptoms*
- Unusual muscle aches
- Arthritis
- Back problems

Neurological
- ☐ *No Symptoms*
- Headaches
- Dizziness
- Stroke
- Weakness
- Numbness

Psychiatric
- ☐ *No Symptoms*
- Depression
- Anxiety
- Substance Abuse
- Change in cognitive function

Endocrine
- ☐ *No Symptoms*
- Unexplained changes in weight
- Goiter
- Excessive thirst
- Increased urination

Hematological
- ☐ *No Symptoms*
- Excessive Bleeding
- Easy bruising

PAST MEDICAL HISTORY

Circle past history

Past Illnesses
- Asthma
- Bronchitis/Emphysema
- Cancer
- Diabetes
- Kidney stones/kidney failure
- Liver/Gallbladder
- Peptic Ulcer - GERD
- Prostate
- Rheumatic Fever
- Seizures
- Sleep Apnea
- Stroke/CVA
- Thyroid Disease

Other ______________________________

____

Infectious Disease History

____

____

Trauma History

____

____

____

Past Cardiac Illnesses
- Angina/Chest Pain
- Atrial Fibrillation
- Congestive heart failure (CHF)
- Coronary artery disease
- Heart Attack (MI)
- High Blood Pressure
- High Cholesterol
- Irregular heartbeat (arrhythmias)
- Peripheral Vascular Disease
- Valvular heart disease

Other ______________________________

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Past Surgeries/Procedures
- Appendectomy
- Back
- Breast
- Cataract
- Gallbladder
- Hernia - Hiatal/Inguinal
- Hip
- Hysterectomy
- Intestinal
- Knee
- Prostate
- Tonsils/Adenoids

Other ______________________________

____

Past Cardiac Surgery/Procedures
- Cardiac Cath
- Cardioversion
- Coronary angioplasty/Stent
- Coronary artery bypass
- EP Study
- ICD
- Pacemaker implant
- RF ablation

SOCIAL HISTORY AND LIFESTYLE

Alcohol Use

Yes No Do you consume alcohol?
Average number per day
_____beer _____wine _____liquor

Smoking/Tobacco Use

Yes No Do you smoke or use tobacco?
Yes No Have you smoked in the past?
Number of years?______ Packs per day______

Diet

Yes No Are you on a special diet?
What type of diet?______________________________
Yes No Do you drink caffeinated beverages? *(coffee, tea, cola, etc.)*
How many daily?______

Exercise

Yes No Do you exercise on a regular basis?
Minimum of 30 minutes / 3 times a week

Substance Abuse

Yes No Do you have a history of drug dependency?
If yes, specify:__________________________________

Lifestyle
- ☐ Single
- ☐ Divorced
- ☐ Married
- ☐ Widowed

Occupation
- ☐ Retired
- ☐ Unemployed

Residence
- ☐ Lives alone
- ☐ Lives with children
- ☐ Lives with parents
- ☐ Lives with spouse
- ☐ Lives with spouse/children
- ☐ Lives with male partner
- ☐ Lives with female partner
- ☐ Nursing home resident
- ☐ Assisted living resident

What do you like to do (hobbies)?

____
____
____
____

FAMILY MEDICAL HISTORY

Family Cardiac History

Father
- ☐ Alive
- ☐ Deceased
  at age______________

- ☐ Heart attack before age 60
- ☐ Stroke
- ☐ Sudden cardiac death

Mother
- ☐ Alive
- ☐ Deceased
  at age______________

- ☐ Heart attack before age 60
- ☐ Stroke
- ☐ Sudden cardiac death

Sibling(s)

_____Number of brother(s)
#______Alive
#______Deceased
at age(s)______________

- ☐ Heart attack before age 60
- ☐ Stroke
- ☐ Sudden cardiac death

_____Number of sister(s)
#______Alive
#______Deceased
at age(s)______________

- ☐ Heart attack before age 60
- ☐ Stroke
- ☐ Sudden cardiac death

Personal Cardiac Risk Factors

- ☐ History of tobacco use
- ☐ Family history heart disease *(immediate family)*
- ☐ History high cholesterol
- ☐ High blood pressure
- ☐ History of diabetes
- ☐ Prior history of heart disease
- ☐ History of obesity
- ☐ Sedentary lifestyle
- ☐ Age *(Male over 45 - Female over 55)*
- ☐ Menopausal female

Do you have an advanced directive/living will?
☐ Yes ☐ No
If yes, could you please provide a copy for our records.