

Patient Name \_\_\_\_\_ MR# \_\_\_\_\_ Date \_\_\_\_\_

Birth day \_\_\_\_\_ Age \_\_\_\_\_ Primary Care MD or Referring MD \_\_\_\_\_

Pharmacy/Address/City/State/Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Reason for today's visit \_\_\_\_\_ Recent Testing (radiology, procedure, lab work?)  Yes  No

What? \_\_\_\_\_ Where? \_\_\_\_\_

Past medical and surgical history? \_\_\_\_\_

## Medical History:

**Have you recently or are you currently experiencing any of the following conditions? (check Yes or No)**

**Constitutional:**  
Yes No

- fever
- chills
- night sweats
- fatigue
- weakness
- light headedness

**Head, Eyes, Ears, Nose, Throat:**

- eye problems
- ear problems
- difficulty swallowing

**Neurological:**

- seizures
- stroke
- passing out
- dizziness

**Blood:**  
Yes No

- excessive bleeding
- excessive bruising
- deep vein thrombosis
- pulmonary embolism

**Vascular:**

- claudication

**Cardiac:**

- difficulty breathing
- diff. breathing sleeping
- diff. breathing walking
- murmur
- rheumatic fever
- palpitations
- chest pain
- chronic malaise

**Skin:**

- rash
- lesions
- cancer

**Pulmonary:**  
Yes No

- asthma
- coughing
- productive coughing
- tuberculosis
- sleep apnea

**Muscular/Skeletal:**  
Yes No

- osteoarthritis
- joint pain
- muscle pain
- rheumatoid arthritis

**Gastrointestinal:**

- change in stool
- blood in stool

**Genitourinary:**

- difficulty urinating
- blood in urine
- urinary tract infection
- renal failure
- kidney stones

**Psychiatric**

- depression
- anxiety

**Are you allergic to any medications?**  Yes  No (list) \_\_\_\_\_

**Are you allergic to IV Dye/Contrast?**  Yes  No

## Social History:

**Marital Status:**  Married  Single  Widowed  Divorced **Do you have an Advanced Plan of Care/Directive?**  Yes  No

**Work Status:**  Employed  Unemployed  Retired  Disabled **Occupation:** \_\_\_\_\_

**Exercise?**  Yes  No **What do you do and how often?** \_\_\_\_\_

**Caffeine?**  Yes  No **What and how much?** \_\_\_\_\_

**Smoke?**  Yes  No **How many packs per day?** \_\_\_\_\_ **How long?** \_\_\_\_\_ **Interested in Quitting?**  Yes  No

**Alcohol?**  Yes  No **What and how much?** \_\_\_\_\_

**Recreational Drugs?**  Yes  No **What and how much?** \_\_\_\_\_

**Cardiac Risk Factors: Diabetes?**  Yes  No **High Blood Pressure?**  Yes  No **High Cholesterol?**  Yes  No

**Exercise?**  Yes  No **Use Tobacco?**  Yes  No **Use Alcohol?**  Yes  No

**Have you received the annual flu vaccination?**  Yes  No **Pneumonia vaccination within the last 5 yrs?**  Yes  No

**Are you currently taking an Aspirin or other antiplatelet daily?**  Yes  No **If other, what?** \_\_\_\_\_

## Family History:

**Are there members of your immediate family with the following conditions or history?**

Heart Disease?  Yes  No  Who? \_\_\_\_\_ Age of 1<sup>st</sup> episode \_\_\_\_\_

Heart surgery?  Yes  No  Who? \_\_\_\_\_ Age of 1<sup>st</sup> episode \_\_\_\_\_

Irregular heart rhythms?  Yes  No  Who? \_\_\_\_\_ Age of 1<sup>st</sup> episode \_\_\_\_\_