BryanLGH Heart Institute

Patient History Form

Clinic Site/Room. # _____BHI Dr. _____ Date _____ Ref. MD _____

PLEASE COMPLETE BLACK PRINTED AREAS

NAME _____
AGE _____DOB_____ SEX F M
ADDRESS _____
_____
PHONE-Hm_____ Wk _____
DESCRIBE YOUR REASON FOR COMING TO SEE US:
_____
_____
_____

CARDIOVASCULAR HISTORY *Circle appropriate response*

1. Chest pain, tightness, heaviness? YES NO
2. Are you short of breath with activity? YES NO
3. Do you wake up at night short of breath? YES NO
4. Do you need more than one pillow to sleep on? YES NO
5. Do your legs and ankles swell? YES NO
6. Heart skips beats or pounds/beats too fast? YES NO
7. Pain in the legs/hips while walking? YES NO
8. Heart attack? YES NO
   If 'Yes,' when?_____
9. Heart catheterization? YES NO
   If 'Yes,' when?_____
10. Heart surgery or balloon procedure? YES NO
    Date_____ Type_____
11. Echocardiogram? (ultrasound of heart) YES NO
12. Blood clots in the legs/lungs? YES NO
13. Varicose veins? YES NO
14. Black-out spells? YES NO
15. Dizziness/Lightheadedness? YES NO
16. Rheumatic fever? YES NO
17. Heart murmur? YES NO

CARDIAC RISK FACTORS *Circle appropriate response*

1. Have you ever smoked/chewed tobacco? YES NO
   a. Packs/day___ b. Years smoked___ c. Year quit____
2. Do you have high blood pressure? YES NO
3. Do you have high blood cholesterol? YES NO
4. Are you diabetic? YES NO
5. Is there a family history of: Please list relationship
   a. Heart Disease YES NO _____
   b. Diabetes? YES NO _____
   c. Cancer? YES NO _____
   d. Stroke? YES NO _____

HABITS/SOCIAL HISTORY *Circle appropriate response*

1. Do you follow a special diet? YES NO
2. Do you use caffeine? YES NO
   Amount/day_____
3. Do you use alcohol? YES NO
   Amount/day_____
4. Have you a history of drug use/addiction? YES NO
5. Occupation_____ Marital Status_____

LIST PREVIOUS OPERATIONS

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS: *Circle appropriate response*

A. GENERAL

a. Tire easily? YES NO
   When did you first notice?_____
b. Recent fever, chills or sweats? YES NO
c. Skin rashes? YES NO
d. Recent weight loss/gain? YES NO

B. EYES

a. Blurry vision? YES NO
b. Glaucoma? YES NO
c. Partial or total loss of vision? YES NO
d. Cataracts? YES NO

C. THROAT AND MOUTH

Problems with nose, teeth, sinus, mouth, throat, ears, hearing? Circle which one(s) YES NO
Describe _____
_____

D. LUNGS

a. Asthma or wheezing? YES NO
b. Emphysema or bronchitis? YES NO
c. Chronic cough? YES NO
d. Bloody sputum? YES NO

E. GASTROINTESTINAL

a. Heartburn/Acid reflux? YES NO
b. Difficulty swallowing? YES NO
c. Hiatal hernia? YES NO
d. Ulcer problems? YES NO
e. Black or bloody stools? YES NO
f. Gall bladder or liver problems? YES NO
g. Recent change in bowel habits? YES NO

F. GENITO-URINARY TRACT

a. Blood in urine? YES NO
b. Problems with urination? YES NO
c. Urinary infections? YES NO
d. Kidney/Bladder stones? YES NO
e. Kidney failure/Dialysis? YES NO
f. Nighttime urination? YES NO
   How often? _____
g. Impotence? YES NO
h. Menopause YES NO

G. MUSCULOSKELETAL *Circle appropriate response*

a. Arthritis? YES NO
b. Gout? YES NO
c. Muscle or Joint pains? YES NO

H. ENDOCRINE

Thyroid problems? YES NO

I. HEMATOLOGY/LYMPHATIC

a. Anemia? YES NO
b. Bruise/bleed easily? YES NO
c. Cancer? YES NO
Type _____

J. NEUROLOGIC

a. Chronic Headaches? YES NO
b. Stroke? YES NO
c. Seizure disorder? YES NO
d. Numbness/tingling? YES NO

K. PSYCHIATRIC

a. History of mental illness? YES NO
b. Problems with depression? YES NO
c. Anxiety problem? YES NO

FOR PHYSICIAN AND NURSE USE ONLY

MEDICATIONS: _____

_____

_____

_____

_____

_____

_____

_____

MEDICATION/LATEX ALLERGIES: _____

_____

VITALS: HT. _____ WT. _____ CHEST _____
B.P. RT. _____/_____ LT. _____/_____
PULSE _____R. _____T. _____

PHYSICAL EXAMINATION:

GENERAL: development distress mood/affect skin

ABD: soft tenderness organomegaly bruits

ENT: xanthelasma oral mucosa

RECTAL/PELVIC:

NECK: carotids JVD thyroid

EXTREM: clubbing/cyanosis pulses edema varicosities bruits

CHEST: respirations lungs AP diameter

HEART: rhythm gallop/murmur palpation

NEURO: IOC grasp gait

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HISTORY:

PLAN:

PHYSICIAN SIGNATURE: _____

Print Name: _____

Date: _____