

Health History Sheet  
Please complete and bring to your office visit

Appointment Date: \_\_\_\_\_ (For office use only) Acct#: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Full time \_\_\_\_\_ Part time \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Referred by: \_\_\_\_\_ Family Dr.: \_\_\_\_\_

Referral Dr. Address: \_\_\_\_\_ Family Dr. Address: \_\_\_\_\_

\_\_\_\_\_

Referral Dr. Phone: \_\_\_\_\_ Family Dr. Phone: \_\_\_\_\_

**Allergies**

Have you ever or are you? **Please check all that apply**

Allergic to any medications: List:	<input type="checkbox"/>	allergic to foods	<input type="checkbox"/>
Allergic to seafood	<input type="checkbox"/>	Allergic to iodine	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	Had a reaction to iodine or IV contrast	<input type="checkbox"/>

**Medications**

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Name of Medication	Dosage	Administering Instructions

**Infection History**

Have you ever had? **Please check all that apply to you**

HIV	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
MAC	<input type="checkbox"/>	TB (Tuberculosis)	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>		<input type="checkbox"/>

### History of Present Illness

Have you recently experienced:	Yes	No
Chest pain/pressure, tightness, heaviness		
Dizziness, passing out, fainting		
Shortness of breath		
Irregular heart beat		
Swelling – where		
Pain in legs with exercise		

### Past Medical History

Have you ever been diagnosed with any of the following? **Please check all that apply to you**

Abdominal Aneurysm		Congestive heart failure/fluid in lungs	
Asthma		Depression	
Anemia		Diabetes	
Anxiety		Emphysema/COPD/Lung problems	
Arthritis		GERD / Acid indigestion	
Cancer-breast		Gout	
Cancer-bladder		Hiatal Hernia	
Cancer-colon		Kidney disease	
Cancer-liver		Leg or hip cramps	
Cancer-lung		Liver disease	
Cancer-pancreas		Menstrual problems	
Cancer-prostate OR prostate enlargement		Neck: large artery blockage	
Cancer-stomach		Parkinson's disease	
Cancer-Uterus		Seizures	
Cancer-Skin		Stomach ulcer or bleeding ulcer	
Colitis		Stroke with or without paralysis	
Congenital heart disease		Thyroid problems	

### Past Cardiac History

Have you ever had? **Please check all that apply to you**

Chest pain (Angina)		High cholesterol	
Congestive Heart Failure		Hypertension	
Heart murmur/Valve disease		Atrial fibrillation (Irregular heart beat)	
Heart attack How many: Date(s):		Coronary artery disease (blockage of heart arteries)	

### Cardiac Risk Factors

Have you ever or do you currently? **Please check all that apply to you**

Smoke cigarettes currently		Diabetes	
Used to smoke but quit		Previous heart disease	
Family history of heart disease (under 50)		History of obesity	
High Cholesterol		Reached menopause	
High blood pressure		Take hormones	

## Cardiac Procedures

Have you ever had? **Please check all that apply to you**

EP Study (Electrophysiology)		Ablation	
Event Monitor		Holter Monitor	
Stress Test		Echocardiogram	
Cardioversion		Kidney / renal procedure	
Heart Catheterization		PTCA (Balloon Angioplasty)	
How many: Date(s)		How many: Date(s)	
Stent placement in artery		Heart bypass surgery	
How many: Date(s):		How many: Date(s):	
Pacemaker / ICD placement		Other	

## Surgical History

Have you ever had any of the following operations? **Please check all that apply to you**

Heart valve replacement		Hip replacement	
Appendectomy		Lung surgery	
Breast surgery		Knee replacement	
Carotid Artery surgery (neck)		Thyroid surgery	
Cataract removal		Prostate surgery (TURP)	
Gallbladder removal		Varicose vein stripped	
Hemorrhoid surgery		Hysterectomy	
IVC Filter		Fistulas	
Ports		Other	

## Social History / Other Cardiac Risk Factors

Do you? **Please check all that apply to you**

Drink alcohol regularly		No Caffeine	
Drink alcohol occasionally/socially		Occasional Caffeine	
Smoke currently		Daily Caffeine	
Used to smoke but quit		No regular exercise	
No diet modifications		Some exercise	
Eat a low salt / low cholesterol diet		Exercise regularly	
Low fat diet		Use of illegal drugs	
Diabetic diet		Single Married Divorced Widowed (circle one)	
Vegetarian diet			

## Family History

Have your father, mother, brothers, or sisters ever had? **Please check all that apply**

Heart Attack		Diabetes	
Congestive heart failure		Heart Valve problems	
Stroke		High blood pressure	
Bleeding disorders		Thyroid disease	
Kidney problems		Family heart problems (prior to age 50)	

## Review of Systems

**Please check all that apply to you:**

<b>General Constitution</b>		<b>Gastroenterology</b>	
Recent weight gain/loss		Change in bowel habits, constipation	
Decreased exercise tolerance		Current blood or mucus in stools	
Fatigue		Feeling of fullness, bloating	
Fever/chills		<b>GI Male/Female</b>	
<b>Integumentary</b>		Urinary problems	
Skin pain/sensitivity		<b>Musculoskeletal</b>	
Rash/hives		Arthritis	
<b>Eyes</b>		Muscle pain/weakness	
Glaucoma		Blood clots in legs	
Wear glasses/contacts		Varicose Veins	
Partial vision loss		<b>Neurological</b>	
Cataracts currently		Difficulty speaking	
<b>Ear Nose Throat</b>		Confusion	
Hearing loss		Dizziness	
Dizziness/positional		<b>Psychiatric</b>	
<b>Respiratory</b>		Depression, anxiety	
Shortness of breath during walking or exercise		<b>Endocrine</b>	
Sleep with more than 1 pillow to help you breath		Thyroid disorders	
Snoring or coughing during sleep		Diabetic	
Unrested when you wake, nap frequently, or fall asleep during the day		<b>Hematological/Immunologic</b>	
<b>Cardiovascular</b>		Bleeding disorders	
Feet/ankle swelling		Nose bleeds	
Blackout or fainting spells		Anemia	
Palpitations			