Associates in Cardiology Health History

Name ______________________________ **Sex/Gender** ___________________ **Date of birth** ___________________

Primary doctor / provider / practice / clinic ____

Reason for visit / description of problem ____

When did it start? ______________________________ **How often is it occurring?** ___________________

What seems to trigger it? ________________________ **Anything make it better or worse?** _______________

Any other symptoms / comments? ____

Circle any that you have ever had: (leave blank to indicate "no", use space to leave comments if desired)

Hypertension / high blood pressure	Amputation	Chronic obstructive pulmonary disease (COPD)	Blood transfusions
High cholesterol	Gestational diabetes mellitus	Emphysema	Blood clots
Diabetes mellitus	Gestational hypertension	Used/using oxygen at home	Bleeding or clotting disorder
Atrial fibrillation	Preeclampsia / eclampsia	Any other lung disease	HIV / AIDS
Other arrhythmia	Rheumatic or scarlet fever	Kidney disease	Hepatitis
Cardiomyopathy	Congenital heart disease	Gout	Psoriasis
Congestive heart failure	Any other heart disease	Fatty liver	Rheumatoid arthritis
Coronary artery disease / blocked or clogged heart arteries	Any heart tests other than an EKG	Liver cirrhosis	Lupus
Carotid artery disease / blocked or clogged neck arteries	Any invasive heart procedures or surgery	Gastrointestinal bleeding	Other autoimmune disorder
Peripheral arterial disease / blocked or clogged leg arteries	Anxiety / depression	Cancer	Any other diseases (please list)
Aortic disease	Other psychiatric diagnosis	- cancer surgery	____________________
Foot ulcers	Stroke / mini stroke / TIA	- chemotherapy	____________________
Gangrene	Seizure	- radiation therapy	____________________
	Sleep apnea	Other outpatient infusion therapy	
	Asthma	Anemia	

Most recent unplanned hospital visit/admission, date and reason: ______________________________

Surgeries (please list) ____

Circle if allergic to: intravenous contrast / iodine dye   iodine   shellfish   latex   tape

Allergies to medications (please list) ____

Medications (dose & frequency if known) (if you have a separate list or brought your medications with you, show the doctor those instead)__

____

____

____

Alcohol: Never   Current (how much / how often) ____________________ Quit, at what age or year: __________

Tobacco: Never   Current (how much / how often) ____________________ Quit, at what age or year: __________

Drugs: Never   Current (how much / how often / what type) ______________ Quit, at what age or year: __________

***** **Form continues ---->**

Occupation ____________________ **Marital status** __________________ **Type of dwelling** ______________________

Who lives with you at home ____

Any particular diet (vegetarian, vegan, etc.) _________________ **Exercise** (what kind, how often for how long) _________________

Family medical history (biological/blood relatives only) | If deceased, cause of death

Father ____ | ______________________________

Mother ____ | ______________________________

Brothers ____ | ______________________________

Sisters ____ | ______________________________

Children (indicate ages/sexes) ____ | ______________________________

Others (indicate relationship) ____ | ______________________________

Circle any you have had within the last 3 months or leading up to / since your symptoms started:

- Other illnesses/medical problems/surgeries
- New medications
- Changes in medications
- Travel
- Changes in life circumstances
- Significant increase in stress
- Fevers
- Unexpected weight loss
- Unexpected weight gain
- Falls/falling
- Sudden loss of vision
- Frequent or severe nose bleeding
- Frequent or severe gum bleeding

- Chest pain at rest
- Chest pain with walking/exertion/exercise
- Shortness of breath at rest
- Shortness of breath with walking/exertion/exercise
- Shortness of breath at night when sleeping
- Wheezing/other noises with breathing
- Coughing without phlegm
- Coughing with phlegm
- Coughing with blood
- Persistent coughing at night when trying to sleep
- Heart racing/fluttering/pounding
- Lightheadedness/dizziness like you might faint/pass out
- Fainting/passing out/falling out

- Swelling of feet/ankles/legs
- Leg or buttock muscle pain with walking/exertion/exercise
- Abdominal bloating
- Early satiety/feeling full quickly when eating
- Nausea/vomiting
- Vomiting blood
- Rectal bleeding
- Blood in stool
- Dark/maroon stool
- Difficulty urinating
- Urinating too frequently at night
- Female: very heavy periods
- Female: # pregnancies ______
- Female: # miscarriages ______

Anything else for us to know about you: ____

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 practice of any changes in my medical status.

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Signature of patient or guardian | Date

Doctor's review

____

Signature of doctor | Date