

MIDWEST HEART SPECIALISTS Medical History

Name _____
Date of Birth _____ Sex _____

Have you had any of the following?

Recent hospitalization When _____ Hospital _____

Recent lab tests When _____ Lab _____

Cardiac tests Type _____
When _____ Where _____

Peripheral vascular ultrasound tests
Type _____
When _____ Where _____

Chief Complaint (State reason for cardiac
consultation) _____

Risk Factors

High blood pressure
Yes No

Smoke..... Yes
No
Former Smoker
If yes or former smoker: No of years__ Packs/day__ Year
Quit _____

High cholesterol..... Yes
No
On cholesterol drug

Diabetes..... Yes
No

Exercise regularly..... Yes
No

Family history of early heart disease or aneurysm Yes No

(If yes, please write in specific details of who in the family <60 years and what type of disease)

.....
.....
.....
.....

Weight (20 lb over ideal)..... Yes
No

Past Medical History

Heart attack.....
Yes No

Angioplasty/stent (please write in when procedure was done and where in your body)..... Yes
No

Congestive heart failure..... Yes
No

Stroke/mini-stroke..... Yes
No

Lung problems (asthma, COPD, pulmonary hypertension)..... Yes
No

Blood clots in legs or lungs
Yes No

Hypothyroid/Hyperthyroid..... Yes
No

Stomach problems (ulcer, hiatal hernia, gastric reflux)..... Yes
No

Liver problems.....
Yes No

Kidney, bladder, prostate problems..... Yes
No

Rheumatic/Scarlet Fever..... Yes
No

Carotid artery blockage..... Yes
No

Eye problems (cataracts, glaucoma, macular degeneration, blind).... Yes
No

Arthritis.....
Yes No

Sleep disorder (sleep apnea, Use CPAP or BiPAP machine)
..... Yes No

Psychiatric problems (anxiety, depression)..... Yes
No Other _____

Surgeries/Procedures (List procedure and year)

Social History

Caffeine intake (cups per day of caffeinated coffee, tea, cola) _____

Alcohol Never Rarely Socially Daily
 No drinks per day/week _____ No years _____

Regular exercise Yes No
 If yes: Type of exercise _____ Times per
 week _____

Diet Diabetic Low fat low cholesterol Low salt
 No special diet Other _____

Marital status Married Single Widow Divorced

Occupation _____

Allergies (List medication and reaction; include food and seasonal allergies) _____

Are you aware of any sensitivity to latex products, i.e., Band-Aids, medical gloves, balloons, etc.?

Medications (List all prescription, nonprescription medications, and nutritional supplements)

Name of Drug	Dose	Times per Day

Review of Systems (Place an "X" by the items that you presently have)

General..... Recent weight loss

Recent weight gain
Fatigue

Eye..... Blurred vision

Double vision
Blind

Ear/Nose/Throat..... Hearing loss

Ringing in ears
Nosebleeds

Cardiovascular System..... Chest pain or pressure

Palpitations

Respiratory..... Shortness of breath

Cough
Hard to breathe lying flat
Cough up blood
Snore

Gastrointestinal..... Blood in stool

Black, tarry stools
Heartburn
Abdominal swelling
Abdominal pain

Kidney/Bladder System..... Blood in urine
Frequent urination

Musculoskeletal..... Arthritic pain
Calf pain with walking
Low back pain

Skin..... Swelling
Rash

Neurologic..... Transient
blurred vision
Weakness on one side
Slurred speech
Numbness
Dizziness
Fainting spells

Hematology..... Bruise easily
Bleeding problems

Name _____