

**MIDWEST HEART SPECIALISTS**  
**Medical History**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Primary Physician \_\_\_\_\_

**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 (60 years or less).....  Yes  No

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

**Past Medical History**

Heart attack.....  Yes  No

Angioplasty/stent.....  Yes  No

Congestive heart failure.....  Yes  No

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

Lung problems.....  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).....  Yes  No

Use CPAP or BiPAP machine.....  Yes  No

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

Other \_\_\_\_\_





**Review of Systems (continued)**

- Kidney/Bladder System.....  Blood in urine  
 Frequent urination at night
- Musculoskeletal.....  Arthritic pain  
 Calf pain with walking  
 Low back pain
- Skin.....  Leg swelling  
 Rash
- Neurologic.....  Transient blurred vision  
 Weakness on one side  
 Slurred speech  
 Numbness  
 Dizziness  
 Fainting spells
- Hematology.....  Bruise easily  
 Bleeding problems

**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\_\_\_\_\_

Name\_\_\_\_\_