Cypress Heart
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Wichita, KS 67226
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Please bring completed history form to your scheduled appointment, if not completed this could delay your office visit.

Thank you

PATIENT HISTORY FORM

Appointment Date_____ Appointment Time_____
Name_____ Referring Physician_____
Date of Birth_____ Soc. Security Number_____
Street Address_____ City/State/Zip_____
Telephone Number(s) h_____ (w) _____

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing

PRESENTING CIRCUMSTANCE

DESCRIBE YOUR PRESENT MEDICAL SYMPTOMS (CHIEF COMPLAINT)
Why are you here? _____
_____
_____

HISTORY OF CHIEF COMPLAINT

Problem	
Onset	___ hours ___ days ___ weeks ___ months ___ years
Location	
Radiation	
Quality	
Duration	
Timing	
Severity	
Aggravating Factors	
Relieving Factors	
Associated S/S	

PAST MEDICAL/SURGICAL HISTORY:

DO YOU HAVE ANY ONGOING ILLNESSES OR PAST MEDICAL CONDITIONS SUCH AS:

	YES	NO		YES	NO		YES	NO
Asthma	☐	☐	Thyroid Disease	☐	☐	Angina/Chest Pain	☐	☐
Bronchitis	☐	☐	Under active (Hypo)	☐	☐	Atrial Fibrillation	☐	☐
Cancer (Where?)	☐	☐	Overactive (Hyper)	☐	☐	Heart Attack (MI)	☐	☐
_____			Peripheral Vascular Disease	☐	☐	Pain in legs with activity	☐	☐
_____			Kidney Failure	☐	☐	Hepatitis	☐	☐
COPD/ Emphysema	☐	☐	Stomach Ulcers	☐	☐	Rheumatic Fever	☐	☐
Stroke/CVA	☐	☐	Seizures	☐	☐	Scarlet Fever	☐	☐
Diabetes	☐	☐	Sleep Apnea	☐	☐			
Insulin	☐	☐	Bleeding Problems	☐	☐			
High Blood Pressure	☐	☐	Other_____	☐	☐			
High Cholesterol	☐	☐	_____					

Revised: 11/17/10

ALLERGY

DO YOU HAVE ANY ALLERGIES TO DRUGS OR FOOD: ☐ YES ☐ NO

Allergy to:	Reaction:

MEDICATION

List all Medications:

Medication Name	Dosage	How often taken?	Who Prescribed?

- **Remember to bring all medications or a current list of medications with you at time of appointment, including dosage and frequency**

REVIEW OF SYSTEMS

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

General:	**YES**	**NO**	
Decreased exercise tolerance?	☐	☐	_____
Fatigue?	☐	☐	_____
Weight Change? ☐ Gain ☐ Loss How much? _____ Period of time? _____	☐	☐	_____
Change in Appetite?	☐	☐	_____
Integumentary (Skin)			
Changes in moles?	☐	☐	_____
Rash?	☐	☐	_____
Itching?	☐	☐	_____
Changes in hair?	☐	☐	_____
Changes in nails?	☐	☐	_____

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Eyes:	**YES**	**NO**	
Do you wear glasses?	☐	☐	_____
Do you have blurred vision?	☐	☐	_____
Do you experience double vision?	☐	☐	_____
Do you have a history of cataracts?	☐	☐	_____
Glaucoma?	☐	☐	_____
Have you experienced visual field loss?	☐	☐	_____

Ears, Nose, and Throat:			
Do you have a hearing deficit?	☐	☐	_____
Dizziness with changing position?	☐	☐	_____
Chronic sinus problems?	☐	☐	_____
Do you have nose bleeds?	☐	☐	_____
Do you wear dentures?	☐	☐	_____
Hoarseness/Change in voice?	☐	☐	_____

Respiratory:			
Do you have a chronic cough?	☐	☐	_____
Productive?	☐	☐	_____
Have you coughed up blood?	☐	☐	_____
Do you experience shortness of breath?	☐	☐	_____
☐ At rest? ☐ With Activity?			
Do you wheeze?	☐	☐	_____
Do you snore?	☐	☐	_____

Cardiovascular:			
Chest pain, pressure or tightness?	☐	☐	_____
☐ at rest? ☐ with activity?			
Heart palpitations (racing)?	☐	☐	_____
Irregular heart beats?	☐	☐	_____
Short of breath lying flat?	☐	☐	How many pillows do you sleep on at night? _____
Waking up panicky short of breath?	☐	☐	_____
Have you passed out?	☐	☐	_____
Swelling of feet or ankles?	☐	☐	_____
Pain in legs with walking?	☐	☐	Describe distance before pain develops _____
Varicose veins?	☐	☐	_____
Nonhealing sores on legs or feet?	☐	☐	_____
History of blood clots or phlebitis?	☐	☐	_____

Gastrointestinal System:			
Frequent nausea?	☐	☐	_____
Frequent vomiting?	☐	☐	_____
Frequent diarrhea?	☐	☐	_____
Problems with constipation?	☐	☐	_____
Blood in Stool?	☐	☐	_____
Gallbladder problems?	☐	☐	_____
Liver Problems?	☐	☐	_____

Genitourinary:			
Do you have pain with urination?	☐	☐	_____
Blood in urine?	☐	☐	_____
Sense of urgency to urinate?	☐	☐	_____
Awaken frequently to urinate?	☐	☐	_____
History or bladder, kidney infection?	☐	☐	_____
History of kidney stones?	☐	☐	_____
Males: Prostate problems?	☐	☐	_____
Females: Post menopausal?	☐	☐	_____

Musculoskeletal:	**YES**	**NO**	
Chronic back pain?	☐	☐	_____
Arthritis?	☐	☐	_____
History of Gout?	☐	☐	_____
History of blood clots in legs?	☐	☐	_____
History of vein ligation or stripping?	☐	☐	_____
Neurological:			
Temporary blurred vision/loss of vision?	☐	☐	_____
Temporary weakness and/or tingling involving an arm or leg?	☐	☐	_____
Severe Headaches?	☐	☐	_____
Migraine Headaches?	☐	☐	_____
Convulsions/Seizures?	☐	☐	_____
Psychiatric:			
Do you have a history of depression?	☐	☐	_____
Do you have chronic anxiety?	☐	☐	_____
Endocrine:			
High Cholesterol?	☐	☐	_____
Diabetes?	☐	☐	_____
Thryoid Problems?	☐	☐	_____
Hematological/Immunologic			
Chronic low blood count/anemia?	☐	☐	_____
Bleeding problems?	☐	☐	_____
Seasonal Allergies?	☐	☐	_____
Latex Allergy?	☐	☐	_____

ILLNESSES	Problem / Date of onset	Problem / Date of onset
Medical		
Cardiac		
Infectious		
Trauma		
PROCEDURES	Procedure / Date	Procedure / Date
Surgeries		
Cardiology Invasive		
Peripheral Vascular		

SOCIAL HISTORY AND LIFESTYLE:

How many alcoholic beverages (beer, wine, or liquor) do you drink on an average day? _____
Do you currently smoke ☐ Yes ☐ No What do you smoke? _____ How much do you smoke? _____
How long have you been smoking? _____ If you quit smoking, when did you quit? _____
How many packs per day did you smoke? _____How many years did you smoke before quitting? _____
Are you on a special diet? ☐ Yes ☐ No What type of diet? _____
How many cups of caffeinated beverages do you drink on an average day? _____
Do you exercise on a regular basis? _____
Do you have a history of drug dependency? ☐ Yes ☐ No If yes, specify_____
Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many children do you have? _____
What was the highest grade of formal education that you finished? _____
Your occupation_____ How many hours per week does it involve? _____
Any heavy physical exertion while working? ☐ Yes ☐ No If yes, what types of things? _____

FAMILY MEDICAL HISTORY

	IF LIVING Age	Health	Age at death	IF DECEASED Cause
Father				
Mother				
Brothers				
Sisters				

Any family history of cardiovascular disease, strokes, diabetes or cancer? Please explain:_____
_____
_____
_____

If you have a **Durable Power of Attorney for Healthcare Needs**, please provide us a copy. This will be included in your electronic medical record for Cypress Heart and allow us to comply with your healthcare directives.

I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

_____ _____
Signed Date