cypress heart

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:_____ C:_____ W:_____

Please list a!! 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 Vase. Disease	[ ]	[ ]	Pain in legs w/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	[ ]	[ ]						

ALLERGY

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?	[ ]	[ ]

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:	**YES**	**NO**
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:	**YES**	**NO**
Do you have a chronic cough?	[ ]	[ ]
Productive?	[ ]	[ ]
Have you coughed up blood?	[ ]	[ ]
Do you experience shortn.ess of breath?	[ ]	[ ]
[ ] At Rest? [ ] With aotivity?		
Do you wheeze?	[ ]	[ ]
Do you snore?	[ ]	[ ]
Cardiovascular:	**YES**	**NO**
Chest pain, pressure or tightness?	[ ]	[ ]
[ ] At Rest? [ ] With activity?		
Heart palpitations (racing)?	[ ]	[ ]
Irregular heart beats?	[ ]	[ ]
Short of breath lying flat?	[ ]	[ ]
Waking up panicky short of breath?	[ ]	[ ]
Have you passed out?	[ ]	[ ]
Swelling of feet or ankles?	[ ]	[ ]
Pain in legs with walking?	[ ]	[ ]
Varicose veins?	[ ]	[ ]
Nonhealing sores on legs or feet?	[ ]	[ ]
History of blood clots or phlebitis?	[ ]	[ ]
Gastrointestinal System:	**YES**	**NO**
Frequent nausea?	[ ]	[ ]
Frequent vomiting?	[ ]	[ ]
Frequent diarrhea?	[ ]	[ ]
Problems with constipation?	[ ]	[ ]
Blood In stool?	[ ]	[ ]
Gallbladder problems?	[ ]	[ ]
Liver Problems?	[ ]	[ ]
Genitourinary:	**YES**	**NO**
Do you have pain with urination?	[ ]	[ ]
Blood In urine?	[ ]	[ ]
Sense of urgency to urinate?	[ ]	[ ]
Awaken frquently to urinate?	[ ]	[ ]
History of bladder, kidney infection?	[ ]	[ ]
History of kidney stones?	[ ]	[ ]
Males: Prostate problems?	[ ]	[ ]
Females: Post menopausal?	[ ]	[ ]

Musculoskeletal:	YES	NO
Chronic back pain?	[ ]	[ ]
Arthritis?	[ ]	[ ]
Hisory of Gout?	[ ]	[ ]
History of blood clots in legs?	[ ]	[ ]
History of vein ligation or stripping?	[ ]	[ ]
Neurological:	**YES**	**NO**
Temporary blurred vision/loss of vision	[ ]	[ ]
Temporary weakness and/or tingling involving an arm or leg?	[ ]	[ ]
Severe Headaches?	[ ]	[ ]
Migraln Headaches?	[ ]	[ ]
Convulsions/Seizures?	[ ]	[ ]
Psychiatric:	**YES**	**NO**
Do you have a history of depression?	[ ]	[ ]
Do you have chronic anxiety?	[ ]	[ ]
Endocrine:	**YES**	**NO**
High Cholesterol?	[ ]	[ ]
Diabetes?	[ ]	[ ]
Thyroid Problems?	[ ]	[ ]
Hematological/Immunologic	**YES**	**NO**
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	Procedures/Date	Procedures/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 smoklng?_____Ifyou 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.

_____ _____

Print Name Date

_____

Signed