UT★Physicians

(Nurse/MA to complete: Ht: _____ Wt: _____ BP: _____ P: _____ Temp: _____ R: _____)

NEW PATIENT ADULT HEALTH HISTORY CARDIOLOGY

Date of visit: _______________________________

Last Name: __________________________________First Name: ______________________________ M.I. _______

Sex: ☐ Male ☐ Female

Reason for today's visit:

____

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Current Medication *(please list all prescription, non-prescription mediations and nutritional supplements)*

Current Medication	Dose (Strength)	Schedule (How many & times per day)	How Long?

Drug Food Allergies

Are you Allergic to:		If allergic, list reaction below
Any Medication	☐ Yes ☐ No	
Iodine, Fish, Shellfish	☐ Yes ☐ No	
X-ray dye or IV Contrast	☐ Yes ☐ No	
Can you take Aspirin	☐ Yes ☐ No	

Who is Your Primary Care Physician (PCP)?

Physician Last Name: _____________________________ First Name: _____________________________________

Office Phone #: __________________________________ Fax #: ____

Address: ____ City: _____________________

St: _______________ Zip Code: _______________________

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Coronary Artery Disease Risk Factor History

High Blood Pressure	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Controlled With	☐ Insulin, how long________________ ☐ Pill ☐ Diet
High Cholesterol	☐ Yes ☐ No
Family History of Heart or Vascular Disease	☐ Yes ☐ No
A History of Rheumatic or Scarlet Fever	☐ Yes ☐ No

Social History

Do you now or have you ever smoked tobacco products	☐ Yes ☐ No
Cigarettes: # of packs per day______________________	# of years: ________________________
Cigars	☐ Yes ☐ No
Pipes	☐ Yes ☐ No
When was your last cigarette, cigar or pipe?	Date: _____________________________
Do You:	
Drink alcohol on a regular basis?	☐ Yes ☐ No
If no, did you drink heavily in the past?	☐ Yes ☐ No
Have you ever been treated for substance abuse?	☐ Yes ☐ No

Diet

☐ Balanced ☐ Low Fat, Low Cholesterol ☐ Low Salt ☐ No Special Diet

☐ Other; please describe____

Activity Level:

Which of the following best describes your level of physical activity both in your daily life and your leisure time?

☐ Exercise strenuously on a regular basis	☐ Do not regularly exercise, but have an active lifestyle
☐ Exercise moderately on a regular basis	☐ Have difficulty accomplishing light chores of daily living
☐ Exercise on an occasional basis	☐ Require assistance to accomplish self-care

Have you ever had any of the following?		Date or Year	Place (Hospital & City)	Complications/Problems
Exam by Cardiologist (Heart Doctor)	☐ Yes ☐ No			
Heart Catheterization or Angiogram	☐ Yes ☐ No			
Coronary Angioplasty (PTCA/Balloon/Stent)	☐ Yes ☐ No			
Exercise Stress Test (Treadmill)	☐ Yes ☐ No			
Echocardiogram (Ultrasound of the Heart)	☐ Yes ☐ No			
Pacemaker/Defibrillator	☐ Yes ☐ No			
Open Heart Surgery	☐ Yes ☐ No			

Previous Operations/Procedures	Year	Surgeon	Place (Hospital & City)	Complications/Problems

Reasons for other Hospitalizations (Non-Surgical Admissions)	Year	Physician	Place (Hospital & City)

Please list all other medical illnesses, any other history of cancer or chronic conditions	How long have you had this?

If you are scheduled for surgery or a hospital stay, please answer the following questions:

Have you or a blood relative had any problems with anesthesia? ☐ Yes ☐ No

If yes, please describe:

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Family History

Relation	**Age**	**Age at Death**	**Cardiac History**
Father:			☐ Yes ☐ No
Mother:			☐ Yes ☐ No
Sister:			☐ Yes ☐ No
Sister:			☐ Yes ☐ No
Brother:			☐ Yes ☐ No
Brother:			☐ Yes ☐ No
Other:			☐ Yes ☐ No
Other:			☐ Yes ☐ No

Please list which family members (blood relatives) have experienced these conditions

Stroke:	Age:
Sudden Death:	Age:
Heart Attack:	Age:
Aneurysm:	Age:
Diabetes:	Age:
Cancer:	Age:
High Blood Pressure:	Age:
High Cholesterol:	Age:
Heart Failure:	Age:
Arteriosclerosis (hardening of the arteries):	Age:

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REVIEW OF SYMPTOMS Please check any current/recent symptoms you have:

Skin:
- ☐ Rashes, Psoriasis or dermatitis
- ☐ Non-healing sores or skin ulcerations

Eyes:
- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Permanent blindness in either eye
- ☐ Cataracts
- ☐ Glaucoma

Heart:
- ☐ Heart attack; what year(s)__________________________
- ☐ Chest discomfort/angina with physical activity
- ☐ Chest discomfort/angina at rest
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath at rest
- ☐ Require more than one pillow at night to breathe well
- ☐ Heart failure or "fluid in lungs"
- ☐ Palpitations; racing or pounding heartbeats
- ☐ Pauses in the heart beat
- ☐ Previously diagnosed heart rhythm disturbance
- ☐ Heart murmur
- ☐ Mitral valve prolapse

Kidneys/Urinary Tract:
- ☐ Kidney disease or failure
- ☐ Enlarged prostate
- ☐ Kidney stones or infection
- ☐ Pain or burning with urination
- ☐ Dribbling or incontinence
- ☐ Multiple trips to bathroom at night
- ☐ Blood in urine during past year
- ☐ History of kidney dialysis; what year___________________________

Blood:
- ☐ Bleeding or bruising tendency
- ☐ Previous blood transfusion
- ☐ Blood disorder; Specify__________
- ☐ Recent fever
- ☐ History of hepatitis or other communicable diseases

Ear/Nose/Throat:
- ☐ Loss of hearing
- ☐ Hearing aids
- ☐ Ringing in the ears
- ☐ Frequent or severe nose bleeds
- ☐ Frequent sinus infections
- ☐ Dentures

Nervous System:
- ☐ Frequent headaches or migraines
- ☐ Epilepsy or seizures; date of last seizure_______________________
- ☐ Depression
- ☐ Nervous disorder; specify________________________

Lungs:
- ☐ Asthma or wheezing
- ☐ Pneumonia
- ☐ Blood clot (embolus) to lungs
- ☐ Coughing up blood
- ☐ Exposure to asbestos
- ☐ Tuberculosis
- ☐ Recent bronchitis or chest cold
- ☐ Emphysema
- ☐ Chronic cough

Metabolism/Endocrine:
- ☐ Thyroid disorder
- ☐ Gout
- ☐ Recent weight gain or loss (>10 lbs)

Circulation:
- ☐ Discoloration of feet or legs
- ☐ Pain in legs or buttocks with exercise
- ☐ Sores or ulcers on feet or legs
- ☐ Blood clot in artery
- ☐ Blood clot in leg vein
- ☐ Ankle or leg swelling
- ☐ Phlebitis of leg veins
- ☐ Sudden visual disturbances in either eye
- ☐ Weakness or paralysis of one side of the body
- ☐ Temporary speech loss or difficulty talking
- ☐ Stroke
- ☐ Dizziness light-headedness or black out spells
- ☐ Aneurysm of any blood vessels
- ☐ Mini-strokes or TIA's

Muscles/Bones/Joints:
- ☐ Arthritis or other joint disease
- ☐ Chronic back trouble
- ☐ Curvature of the spine (scoliosis)

Reproductive (for Women):
- ☐ Are you or might you be pregnant?
- ☐ Date or year of last period_________

Reproductive (for Men):
- ☐ Have you had a vasectomy?
- ☐ Erectile Dysfunction

Stomach/Intestines:
- ☐ Dark, tarry stools
- ☐ Chronic constipation
- ☐ Stomach ulcer or peptic ulcer
- ☐ Liver disease or jaundice; what year______________________
- ☐ Frequent heartburn or indigestion
- ☐ Frequent diarrhea

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Do you have any other special concerns or additional information we should be aware of regarding your care?

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

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Patient Signature **Date**