Missouri Heart Center
Missouri Cardiovascular Specialists
Phone (573) 256-7700 * Fax (573) 256-3003

PATIENT HISTORY FORM

Name_____**Date of Birth**_____**M/F**

Date and Time of Appointment_____

Referring Physician_____**Preferred Pharmacy**_____

Reason for Appointment_____**Height**_____

PHYSICIANS (Please list all doctors and/or practitioners providing healthcare)

Doctor's Name	**Type of Doctor** *Primary Care, Oncology, etc.*	**Reason for seeing this doctor**

ALLERGIES **Do you have ANY allergies to drugs or foods? YES or NO**

Allergy–list medication, foods, latex, etc.	**Reaction–rash, shortness of breath, hives, itching, etc.**

CURRENT MEDICATIONS **Please list ALL prescription medications, over-the-counter medications and vitamins!!**

Medication	**Dosage (mg, mcg, etc.)**	**How often do you take?**	**Prescribing Physician**

REVIEW OF SYSTEMS **Circle if you are experiencing symptoms or check "No symptoms"**

General
☐ *No symptoms*
Recent fever/chills
Recent weight loss/gain
How much?_____lbs.

Integumentary (Skin)
☐ *No symptoms*
Rash (of any kind)
Changes in nails or hair
Changes in moles

Eyes
☐ *No symptoms*
Blurred vision
Double vision
Wear glasses
Glaucoma
Cataracts
Legally blind

Ears, Nose & Throat
☐ *No symptoms*
Hearing loss (hearing aid?)
Nose bleeds
Seasonal sinusitis

Psychiatric
☐ *No symptoms*
Anxiety
Stress
Depression
History of alcoholism
History of drug abuse

Respiratory
☐ *No symptoms*
Cough (dry or productive)
Coughing up blood
History of asthma, COPD or emphysema
Snoring
Short of breath at rest or exertion

Cardiovascular
☐ *No symptoms*
Chest pain, pressure, tightness or discomfort
Have you passed out?
Palpitations/irregular heart beats
Shortness of breath lying flat
Swelling of feet or ankles
History of blood clots or phlebitis

Gastrointestinal
☐ *No symptoms*
Blood in stools
Black, tarry stools
Heartburn or peptic ulcers
Acid reflux (GERD)

Musculoskeletal
☐ *No symptoms*
Muscle weakness/pain/cramps
Back pain (chronic)
Arthritis, generalized
Rheumatoid arthritis
Swelling (if so, where_____?)

Genitourinary
☐ *No symptoms*
Blood in urine
Pain with urination
History of kidney stones
Prostate problems (males only)

Neurological
☐ *No symptoms*
Headaches
Numbness/tingling on one side
Weakness on one side
Dizziness
History of TIA, stroke or seizures

Endocrine
☐ *No symptoms*
Increased fatigue
Diabetes (Do you take insulin?)
Excessive thirst
Increased urination
Hyperlipidemia
Hyperthyroidism/hypothyroidism

Hematological
☐ *No symptoms*
Bleed easily
Bruise easily
B_{12} deficiency
Bleeding disorders (anemia, etc.)
Seasonal allergies

If you are experiencing chest pain of any kind, please describe the pain/discomfort. Are there any specific activities that seem to cause the pain? Does the pain radiate into you neck, jaw, arm, or back? Does it come on with exercise only, or does it also occur at rest? Did you experience any nausea or vomiting? Also, please describe any other symptoms you are having not mentioned above.

PAST MEDICAL HISTORY

Circle past history below

Past Illnesses
Anemia
Arthritis
Asthma
Bronchitis
Cancer, if yes, what kind_____?
Carotid artery disease
Depression
Diabetes, if yes, are you on insulin_____?
Erectile dysfunction
Gastrointestinal bleeding
Kidney stones/kidney failure/hemodialysis
Liver/gallbladder
Peptic ulcer – GERD
Prostate
Rectal bleeding
Seizures
Sleep apnea, if yes, do you wear CPAP/BIPAP?
Stroke/CVA/TIA
Thyroid disease
Other_____
_____
_____

Infectious Diseases
Rheumatic fever
Scarlet fever
Chickenpox, measles, mumps, or rubella
Tuberculosis (TB)
Hepatitis A, B, C, D or E
HIV/AIDS
Other_____
_____
_____

Past Cardiac Illnesses
Angina/chest pain
Atrial fibrillation (A-fib)
Congestive heart failure (CHF)
Coronary artery disease (CAD)
Heart attack (MI)
High blood pressure
High cholesterol
Irregular heartbeat (arrhythmias)
Peripheral Vascular Disease/Claudication
Pulmonary Hypertension
Endocarditis
Other_____
_____
_____
_____

Surgeries/Procedures/Dates
Appendectomy
Back
Breast
Carotid
Cataract
Gallbladder
Hernia – hiatal/inguinal
Hip
Hysterectomy
Intestinal
Knee
Amputation
Lung
Bariatric (gastric bypass, LAP-BAND)
Other_____
_____

Trauma History
Motor-vehicle accident
Other_____
_____
_____
_____

Cardiac surgery/procedures (Please provide dates and location and name of doctor if available)
Cardiac catheterization_____
Coronary angioplasty/stent_____
Electrophysiology study_____
Pacemaker_____
Heart valve surgery_____
Cardioversion_____
Coronary artery bypass_____
Implantable cardiac defibrillator (ICD)_____
Radiofrequency ablation_____

PAD Questionnaire
How far can you walk before experiencing leg pain/fatigue or aching? Is it relieved with rest?_____
_____
Does leg pain prevent you from walking normally, with family/friends, or shopping? Is it relieved with rest?_____
_____
Any changes in toenails?_____
Poor or non-healing wounds of legs or feet?_____
Do you ever experience coolness or pallor of feet?_____
Do you have a history of any other vascular abnormalities (carotid artery stenosis, abdominal aortic aneurysm, renal artery stenosis, or coronary artery disease)?_____
_____

SOCIAL HISTORY & LIFESTYLE

Alcohol use

Do you consume alcohol? **YES NO**
Average number per day/week/month? Beer_____Wine_____Liquor/mixed drinks_____

Smoking/Tobacco use

Do you smoke cigarettes/smokeless cigarettes or use tobacco? **YES NO** Are you currently smoking? **YES NO**
Have you smoked in the past? **YES NO** How many years?_____Packs per day?_____

Diet

Are you on any special diet (diabetic diet, etc.)? **YES NO** If yes, what type?_____
Do you drink caffeinated beverages? **YES NO** If yes, how many per day?_____
(coffee, tea, soda, etc.)

Exercise

Do you exercise on a regular basis? **YES NO** If so, what type of exercise?_____
(minimum of 30 minutes per day, at least 3 times per week)

Substance abuse

Do you have any history of drug use? **YES NO**
If yes, please specify_____

Lifestyle

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered

Occupation

Please list_____
☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

Residence

☐ Lives alone
☐ Lives with spouse
☐ Lives with partner
☐ Lives with parents
☐ Lives with children
☐ Nursing home resident
☐ Assisted living resident

PERSONAL CARDIAC RISK FACTORS

☐ History of tobacco use
☐ Family history of heart disease *(immediate family, mother, father, brother, sister)*
☐ History of high cholesterol
☐ History of high blood pressure
☐ History of diabetes
☐ Prior history of heart disease
☐ History of obesity
☐ Sedentary/inactive lifestyle
☐ Age *(Male over age 45 – Female over age 55)*
☐ Menopausal female

FAMILY MEDICAL HISTORY

Father

☐ Alive
☐ Deceased (at what age?)____________
Cause of death?___________________
____
Other______________________________
____
____
____

☐ Heart attack (at what age_____?)
☐ Stroke
☐ Sudden cardiac death
☐ Coronary artery disease
☐ Congestive heart failure
☐ Congenital heart disease
☐ High blood pressure
☐ Cancer (please list what kind_______________)

☐ Diabetes
☐ Hypertension

Mother

☐ Alive
☐ Deceased (at what age?)____________
Cause of death?___________________
____
Other______________________________
____
____
____

☐ Heart attack (at what age_____?)
☐ Stroke
☐ Sudden cardiac death
☐ Coronary artery disease
☐ Congestive heart failure
☐ Congenital heart disease
☐ High blood pressure
☐ Cancer (please list what kind_______________)

☐ Diabetes
☐ Hypertension

Sibling(s) Please specify brothers or sisters

☐ Alive
☐ Deceased (at what age?)____________
Cause of death?___________________
____
Other______________________________
____
____
____

☐ Heart attack (at what age_____?)
☐ Stroke
☐ Sudden cardiac death
☐ Coronary artery disease
☐ Congestive heart failure
☐ Congenital heart disease
☐ High blood pressure
☐ Cancer (please list what kind_______________)

☐ Diabetes
☐ Hypertension

☐ Alive
☐ Deceased (at what age?)____________
Cause of death?___________________
____
Other______________________________
____
____
____

☐ Heart attack (at what age_____?)
☐ Stroke
☐ Sudden cardiac death
☐ Coronary artery disease
☐ Congestive heart failure
☐ Congenital heart disease
☐ High blood pressure
☐ Cancer (please list what kind_______________)

☐ Diabetes
☐ Hypertension

☐ Alive
☐ Deceased (at what age?)____________
Cause of death?___________________
____
Other______________________________
____
____
____

☐ Heart attack (at what age_____?)
☐ Stroke
☐ Sudden cardiac death
☐ Coronary artery disease
☐ Congestive heart failure
☐ Congenital heart disease
☐ High blood pressure
☐ Cancer (please list what kind_______________)

☐ Diabetes
☐ Hypertension

<u>Please feel free to write in the margins of any page or attach your own additional paper if you need more room.</u>