Missouri Heart Center
Missouri Cardiovascular Specialists

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Macon Office
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Mexico Office
Phone (573)581-3240
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Sedalia Office
Phone (660)827-1771
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Please bring completed forms to your first appointment.
Please bring a copy of any recent lab work or testing.

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

Primary Care Physician_____ **Pharmacy**_____

Reason for Appointment_____ **Height**_____

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?**

PERSONAL CARDIAC RISK FACTORS **Check all that apply to you**

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

PAST MEDICAL HISTORY **Check all that apply to you**

☐Previously healthy with no significant history
☐Adrenal Insufficiency
☐Amyloid
☐Anemia
☐Anxiety
☐Asthma
☐Alzheimer's Disease
Arthritis: ☐Generalized
☐Gouty
☐Osteo
☐Rheumatoid
☐Autoimmune Disorder
☐Bicep Tear
☐Bipolar Disease
☐Birth Complications: Miscarriage, Still birth
☐Blind
☐BPH/Prostate Issues
☐Barrett's Esophagus
☐Bell's Palsy
☐Bronchitis-Chronic
☐Carpal tunnel
☐Cataracts
☐Cellulitis
☐Cirrhosis
☐Colitis
☐Crohn's
☐COPD/Emphysema
☐CVA/Stroke/TIA
☐Cancer, if yes, what kind: _____?
☐Degenerative Joint Disease
☐Dementia
☐Depression
☐Diabetes: Type: ☐ I ☐II
☐Diabetic Neuropathy
☐Diverticulitis
☐DVT
☐Endometriosis
☐Erectile dysfunction
☐Esophagitis
☐Fibromyalgia
☐Gastric Ulcer
☐Glaucoma
☐GI Bleed
☐Gallbladder Disease
☐GERD
☐Gout
☐Hemorrhoids
☐Hernia
☐HIV
☐Hodgkin's Disease
☐Hyperlipidemia (High Cholesterol)
☐Hypertension
☐Hyperthyroid
☐Hypothyroid
☐Irritable Bowel Syndrome
☐Kidney Stone
☐Leukemia
☐Lupus
☐Lymphoma
☐Macular Degeneration
☐Migraine Headaches
☐Obesity
☐Osteoporosis
☐Pancreatitis
☐Parkinson's Disease
☐Peripheral Neuropathy
☐Polycystic Kidney Disease
☐Pulmonary Embolus
☐Pulmonary Fibrosis
☐Preeclampsia
☐Raynaud's Phenomenon
☐Renal Insufficiency
☐Renal Failure
☐Sarcoid
☐Scoliosis
☐Seizures
☐Sleep Apnea
☐Spinal Stenosis
☐Syncope (Passing Out)/Near
☐Trigeminal Neuralgia
☐Ulcer Disease
☐Varicose Veins
☐Vertigo
☐Other: _____
_____
_____
_____

PAST CARDIAC HISTORY

Check all that apply to you

☐No previous history of cardiac disease
☐AAA
☐Aortic Aneurysm
☐ASD (Atrial Septal Defect)
Arrhythmia: ☐A-Fib (Atrial Fibrillation)
☐A-Flutter (Atrial Flutter)
☐Bradycardia
☐PAC's/PVC's
☐Palpitations
☐SVT
☐Tachycardia
☐CAD (Coronary Artery Disease)
☐Cardiomyopathy
☐Carotid Artery Stenosis
☐CHF (Congestive Heart Failure)
Claudication: ☐Right ☐Left ☐Bilateral
☐Endocarditis
☐Murmur
☐PFO (Patent Foramen Ovale)
☐Pericarditis
☐Pulmonary Edema
☐Pulmonary Valve Stenosis
☐Pulmonary Hypertension
☐PVD (Peripheral Vascular Disease)
☐Rheumatic Heart Disease
☐Sick Sinus Syndrome
☐Sudden Death
☐MI (Myocardial Infarction)
☐Myocarditis
☐S/P Cardiac Stent: _____
Valve Disease:
Aortic: ☐Stenosis ☐Regurgitation
Mitral: ☐Stenosis ☐Regurgitation ☐Prolapse
Tricuspid: ☐Stenosis ☐Regurgitation
☐(VSD) Ventricular Septal Defect
☐Ventricular Tachycardia
☐WPW
☐Other: _____
_____
_____
_____

INFECTIOUS HISTORY

Check all that apply to you (Please provide month/year if available)

☐No history of infectious diseases
☐Childhood illnesses of mumps, measles and chickenpox
☐Chickenpox: _____
☐Clostridium Difficile: _____
☐COVID-19: _____
☐Diphtheria: _____
☐Gonorrhea: _____
☐Histoplasmosis: ____ _____
☐HIV: _____
Hepatitis: _____
☐A ☐B ☐C
☐Herpes: _____
☐Shingles: _____ _____
☐Malaria: _____
☐Meningitis: _____ _____
☐Measles: _____
☐Mumps: _____
☐Rheumatic Fever: _____
☐Pneumonia: _____
☐Scarlet Fever: _____
☐Syphilis: _____ _____
☐Tuberculosis: _____
☐Typhoid Fever: _____
☐Polio: _____
☐Guillain-Barre: _____ _____
☐Sternal Wound
☐Tick borne disease: _____
☐Vaccinations: _____
_____
_____

Trauma History **Check all that apply to you (Please provide year if available)**

☐No history of trauma
☐Burns (Major) : ____ _____
☐Skull Fracture: _____ _____
☐Concussion: _____ ____
☐Fracture: _____ _
Location: _____ _____
☐Traumatic Amputation: _____

☐Gunshot Wound: _____
☐Stab Wound: _____
☐Traumatic Brain Injury
☐Wounded in the War: _____
War: _____

SURGERIES **Check all that apply to you (Please provide year if available)**

☐No prior surgical procedures
☐AAA-Repair :_____ _____
☐AKA (Above the knee amputation) R / L: _____
☐Ankle Surgery: _____
☐AVR (Aortic Valve Replacement) :_____ ___
☐Appendectomy:_____ _____
☐ASD Repair:_____ _____
☐Back Surgery:_____
☐Bicep Repair:_____
☐BKA (Below the knee amputation) :_____ ____
☐Bladder Surgery: _____
☐Breast Surgery: _____
☐CABG (Coronary Artery Bypass): _____
☐Redo-CABG: _____
☐Carotid Endarterectomy: _____
☐Cataract Extraction: _____
☐Carpal Tunnel Release: _____
☐Cesarean Section: _____
☐Colonoscopy: _____
☐Gallbladder (Cholecystectomy): _____
☐Colectomy: _____
☐D &C: _____ _____
☐Endometrial Ablation: _____
☐Elbow Surgery: _____
☐Exploratory Lap: ____ _____
☐Eye Surgery: _____
☐Fem-Pop Bypass: _____
☐Foot Surgery: _____
☐Gastric Surgery: _____
☐Hand Surgery: _____

☐Heart Transplant: _____
☐Hemorrhoidectomy: _____
☐Hysterectomy: _____
☐Hernia Repair: _____
☐Hip Surgery: _____
☐Knee Surgery: _____
☐Lung Surgery: _____
☐MVR (Mitral Valve Replacement): _____
☐Nasal Surgery: _____
☐Neck Surgery: _____
☐Nephrectomy: _____
☐Parathyroidectomy: _____
☐Pericardiocentesis: _____
☐PFT's (Pulmonary Function Testing): _____
☐Prostate Surgery: _____
☐Pseudo Aneurism Injection: _____
☐Shoulder Surgery: _____
☐Sleep Study: _____
☐Thyroidectomy: _____
☐Tonsillectomy: _____
☐Tonsillectomy/Adenoids: _____
☐Tubal Ligation: _____
☐TURP: _____
☐VQ Scan: _____
☐Vasectomy: _____
☐Vein Stripping: _____
☐Other: _____
_____
_____

SOCIAL HISTORY & LIFESTYLE

Alcohol use

Do you consume alcohol? ☐**YES** ☐ **NO** ☐History of Alcohol Abuse

If Yes: How many drinks? _____ ☐Daily ☐Weekly ☐Monthly

1 Standard drink = 12oz beer, 5oz wine, 1.5oz (standard jigger) liquor

Smoking/Tobacco use

Do you currently smoke *cigarettes/smokeless cigarettes* or use *other tobacco* (Circle Type)? ☐**YES** ☐**NO**

Have you smoked in the past? ☐**YES** ☐**NO** How many years did you smoke _____Packs per day?_____

When did you quit? _____

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

☐No Regular Exercise ☐Some exercise ☐Exercises daily

☐Exercises on regular basis ***(30 minutes per day, at least 3 times per week)***

Type: ☐Aerobics ☐Running/Jogging ☐Walking ☐Weight Lifting

Other:_____

Substance abuse

Do you have any history of drug use? ☐**YES** ☐**NO**

If yes, please specify_____

Any IV Drug use? ☐**YES** ☐**NO**

Lifestyle

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

Occupation

Please list: _____

☐Retired ☐Unemployed ☐Student

Residence

☐Lives alone ☐Lives with others' ☐Lives in a healthcare facility

FAMILY MEDICAL HISTORY

☐Unknown ☐Adopted

Father

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

☐Heart attack (at what age_____?)
☐Stroke ☐Diabetes
☐Cancer (please list what kind _____)
☐Coronary artery disease ☐Congestive heart failure
☐Congenital heart disease ☐High blood pressure

Mother

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

☐Heart attack (at what age_____?)
☐Stroke ☐Diabetes
☐Cancer (please list what kind _____)
☐Coronary artery disease ☐Congestive heart failure
☐Congenital heart disease ☐High blood pressure

Sibling(s)

☐Brother ☐Sister

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

☐Heart attack (at what age_____?)
☐Stroke ☐Diabetes
☐Cancer (please list what kind _____)
☐Coronary artery disease ☐Congestive heart failure
☐Congenital heart disease ☐High blood pressure

☐Brother ☐Sister

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

☐Heart attack (at what age_____?)
☐Stroke ☐Diabetes
☐Cancer (please list what kind _____)
☐Coronary artery disease ☐Congestive heart failure
☐Congenital heart disease ☐High blood pressure

Children: _____

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

☐Heart attack (at what age_____?)
☐Stroke ☐Diabetes
☐Cancer (please list what kind _____)
☐Coronary artery disease ☐Congestive heart failure
☐Congenital heart disease ☐High blood pressure

REVIEW OF SYMPTOMS (Please check if you are currently experiencing symptoms or indicate *No Symptoms*)

General

☐*No Symptoms*

☐Fatigue ☐Decreased exercise tolerance

Unplanned recent weight ☐loss ☐gain

How Much?_____ lbs.

☐Recurrent chills and fever

☐Other:_____

Integumentary

☐*No Symptoms*

☐Rash ☐Itching ☐Skin Lesions

☐Other:_____

Eyes

☐*No Symptoms*

☐Decreased acuity ☐Blind

☐Double vision (diplopia) ☐Changes in vision

☐Other:_____

Ears, Nose & Throat

☐*No Symptoms*

Hearing loss: ☐Partial ☐Complete

☐Difficulty speaking ☐Nose bleeds

☐Other:_____

Respiratory

☐*No Symptoms*

Cough: ☐Dry ☐Productive

Shortness of breath (Dyspnea):

☐At Rest ☐With Exertion

☐Coughing up blood (Hemoptysis)

☐Wheezing

☐Other:_____

Cardiovascular

☐*No Symptoms*

☐Chest pain ☐Palpitations

☐Dizziness

☐Swelling: ☐Ankles ☐Legs

Short of breath: ☐At rest ☐With exertion

☐Short of breath lying flat (orthopnea)

☐Passing out (syncope)

☐Leg fatigue/pain when walking

☐Non-healing wounds

☐Other:

Gastrointestinal

☐*No Symptoms*

☐Nausea ☐Abdominal discomfort

Blood in stool:

☐Bright ☐Dark/Tarry

☐Diarrhea ☐Constipation

☐Other:_____

Musculoskeletal

☐*No Symptoms*

☐Chronic back pain ☐Joint pain

☐Muscle weakness

☐Other:_____

Neurological

☐*No Symptoms*

☐Confusion ☐Headaches

☐Vertigo

☐Other:_____

Psychiatric

☐*No Symptoms*

☐Feelings of anxiety or depression

Change in:

☐Behavior ☐Mood ☐Personality

☐Other:_____

Endocrine

☐*No Symptoms*

☐Excessive thirst (polydipsia)

☐Excessive urination (polyuria)

☐Intolerance to cold

☐Other:_____

Hematological/Immunological

☐*No Symptoms*

☐Bleeding disorder

☐Easy Bleeding ☐Easy Bruising

☐ Swollen Lymph Nodes

☐Other:_____