

# *Thoracic and Cardiovascular Institute*

## PATIENT HISTORY FORM

**Please complete this form and bring it with you to your appointment**

Appointment Date \_\_\_\_\_ Appointment Time \_\_\_\_\_

Name \_\_\_\_\_ Referring Physician \_\_\_\_\_

Date of Birth \_\_\_\_\_

**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? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### PAST MEDICAL/SURGICAL HISTORY:

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

	YES	NO		YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Underactive (Hypo)	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Overactive (Hyper)	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Where?)	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (MI)	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	Pain in legs with activity	<input type="checkbox"/>	<input type="checkbox"/>
COPD/ Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis – A, B, or C.	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>				High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Other _____								

ILLNESSES	Problem / Date of onset	Problem / Date of onset
Other Medical Conditions		
Other Cardiac Conditions		
Other Infectious Diseases I have had .....	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Mumps	
Trauma (broken bones or major injuries)?	<b>Please list:</b>	



**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 If yes, what do you smoke?  cigarette  cigar  pipe  chewing tobacco.

How long have you been smoking? \_\_\_\_\_ If you quit smoking, when did you quit? \_\_\_\_\_

How many packs per day do or did you smoke? \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, what type of diet? \_\_\_\_\_

How many cups of caffeinated beverages do you drink on an average day? \_\_\_\_\_

Do you exercise on a regular basis?  Yes  No If yes, what kind of exercise? \_\_\_\_\_

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? \_\_\_\_\_

Current or previous occupation \_\_\_\_\_ Retired:  Yes  No

If you currently work, how many hours per week does it involve? \_\_\_\_\_

Any heavy physical exertion while working?  Yes  No If yes, what types of things? \_\_\_\_\_

**REVIEW OF SYSTEMS**

<b>Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.</b>			
<b>GENERAL:</b>	<b>YES</b>	<b>NO</b>	
Change in exercise tolerance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Increased or <input type="checkbox"/> Decreased
Fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	
Weight Change? <input type="checkbox"/> Gain or <input type="checkbox"/> Loss How much? _____ Period of time? _____	<input type="checkbox"/>	<input type="checkbox"/>	
Change in Appetite?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>INTEGUMENTARY (SKIN):</b>	<b>YES</b>	<b>NO</b>	
Changes in moles?	<input type="checkbox"/>	<input type="checkbox"/>	
Rash? Location of rash: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Itching? Location of itching: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in hair?	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in nails?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>EYES:</b>	<b>YES</b>	<b>NO</b>	
Do you wear glasses/contacts?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you experience double vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you experienced visual field loss?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have macular degeneration?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>EARS, NOSE and THROAT:</b>	<b>YES</b>	<b>NO</b>	
Do you have a hearing deficit?	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness with changing position?	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.</b>			
<b>EARS, NOSE and THROAT: (continued)</b>	<b>YES</b>	<b>NO</b>	
Do you have nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness/Change in voice?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>RESPIRATORY: (Lungs)</b>	<b>YES</b>	<b>NO</b>	
Do you have a chronic cough? Is it Productive? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
Have you coughed up blood?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you experience shortness of breath? <input type="checkbox"/> At rest? or <input type="checkbox"/> With Activity?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wheeze?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>CARDIOVASCULAR: (Heart)</b>	<b>YES</b>	<b>NO</b>	
Chest <input type="checkbox"/> pain <input type="checkbox"/> pressure <input type="checkbox"/> tightness or <input type="checkbox"/> heaviness? <input type="checkbox"/> At rest? or <input type="checkbox"/> With activity?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart palpitations: <input type="checkbox"/> skipping <input type="checkbox"/> fluttering <input type="checkbox"/> racing	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular heart beats?	<input type="checkbox"/>	<input type="checkbox"/>	
Short of breath lying flat?	<input type="checkbox"/>	<input type="checkbox"/>	How many pillows do you sleep on at night?
Wake up panicky and/or short of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you passed out?	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of feet or ankles?	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in legs with walking?	<input type="checkbox"/>	<input type="checkbox"/>	Describe distance before pain develops:
Varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	
Non-healing sores on legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	
History of blood clots or phlebitis?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GASTROINTESTINAL SYSTEM: (Stomach)</b>	<b>YES</b>	<b>NO</b>	
Frequent nausea?	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent heartburn?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, is it before or after meals?
Frequent vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with constipation?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in Stool?	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Problems?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENITOURINARY: (Urinary)</b>	<b>YES</b>	<b>NO</b>	
Do you have pain with urination?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	
Sense of urgency to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	
Awaken frequently to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	
History of <input type="checkbox"/> bladder or <input type="checkbox"/> kidney infection?	<input type="checkbox"/>	<input type="checkbox"/>	
History of kidney stones?	<input type="checkbox"/>	<input type="checkbox"/>	
Males: Prostate problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Females: Post menopausal?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, are you on hormone replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>GYNECOLOGICAL SYSTEM (Women Only)</b>			
Number of pregnancies? _____ Number of deliveries? _____			
Date of last Pap Test? _____ Was last pap test normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last menstrual period? _____			

<b>Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.</b>			
<b>MUSCULOSKELETAL: (Muscle and Bone)</b>	<b>YES</b>	<b>NO</b>	
Chronic back pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis? <input type="checkbox"/> Osteo or <input type="checkbox"/> Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	
History of Gout?	<input type="checkbox"/>	<input type="checkbox"/>	
History of blood clots in legs?	<input type="checkbox"/>	<input type="checkbox"/>	
History of vein ligation or stripping?	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NEUROLOGICAL:</b>	<b>YES</b>	<b>NO</b>	
Temporary <input type="checkbox"/> blurred vision or <input type="checkbox"/> loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which eye <input type="checkbox"/> <b>Right</b> <input type="checkbox"/> <b>Left</b>
Temporary <input type="checkbox"/> numbness <input type="checkbox"/> tingling <input type="checkbox"/> weakness of arm?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which arm <input type="checkbox"/> <b>Right</b> <input type="checkbox"/> <b>Left</b>
Temporary <input type="checkbox"/> numbness <input type="checkbox"/> tingling <input type="checkbox"/> weakness of leg?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which leg <input type="checkbox"/> <b>Right</b> <input type="checkbox"/> <b>Left</b>
Fainting?	<input type="checkbox"/>	<input type="checkbox"/>	
Severe Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions/Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>PSYCHIATRIC: (Mental Health)</b>	<b>YES</b>	<b>NO</b>	
Do you have a history of depression?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have chronic anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ENDOCRINE:</b>	<b>YES</b>	<b>NO</b>	
High Cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Problems?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>HEMATOLOGICAL/IMMUNOLOGIC:</b>	<b>YES</b>	<b>NO</b>	
Chronic low blood count/anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Seasonal Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	
Latex Allergy?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>SLEEP HISTORY:</b>	<b>YES</b>	<b>NO</b>	
Daytime sleepiness and/or excessive fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	
Loud or irregular snoring?	<input type="checkbox"/>	<input type="checkbox"/>	
Been told that you hold your breath when you sleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Wake up and find it difficult to catch your breath?	<input type="checkbox"/>	<input type="checkbox"/>	
Have restless sleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Wake up with headaches on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you choke at night?	<input type="checkbox"/>	<input type="checkbox"/>	
Extremity jerking during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Wake up with acid-like taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
Use <input type="checkbox"/> CPAP or <input type="checkbox"/> BIPAP	<input type="checkbox"/>	<input type="checkbox"/>	
Have <input type="checkbox"/> CPAP or <input type="checkbox"/> BIPAP but do not use?	<input type="checkbox"/>	<input type="checkbox"/>	