## Cardiology Clinical History Form

First Name:_____ Middle:_____ Last:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Gender: ❑ Male ❑ Female ❑ Other

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Work Phone:( )_____-_____ Primary Physician: _____

Occupation: _____ Marital Status: _____ Number of Children: _____

## Chief Complaint and Present Illness.

**Reason for Consultation:** ❑ Abn Echocadiogram ❑ ABN EKG ❑ Angina ❑ CAD ❑ Cardiac Arrythmia ❑ CHF ❑ HTN ❑ MI ❑ Pulmonary Edema ❑ Pulmonary Edema ❑ Stress Test ❑ Syncope ❑ Unstable Angina ❑ Physical Exam Other: _____

**List All Symptoms:** _____

**If Symptom Includes Pain Check The One(s) That Best Describe:** ❑ Aching ❑ Burning ❑ Continuous ❑ Cramping ❑ Deep ❑ Dull ❑ Gnawing ❑ Gradual ❑ Intermittent ❑ Mild ❑ Moderate ❑ Periodic ❑ Sharp ❑ Shifting ❑ Stabbing ❑ Sudden ❑ Superficial Other: _____

**Risk Factors For CAD:** ❑ CABG ❑ Elevated LDL ❑ F.H. of CVA ❑ F.H. of MI ❑ Hyperlipidemia ❑ Low HDL ❑ Obesity ❑ Sedentary Lifestyle ❑ Smoking

**Duration:** _____ **Location(s):** _____ **Historian:** _____

**Date Symptom(s) Began:**____ **Frequency of Symptom(s):** ❑ ____X Per Day ❑ ____X Per Week ❑ ____X Per Month ❑ ____X Per Year ❑ Constant ❑ Intermittent ❑ Occasional ❑ Rare ❑ Recurrent Other: _____

**Intensity of Symptoms:** ❑ Excruciating ❑ Mild ❑ Moderate ❑ Severe Other: _____

**How Did Symptom(s) Start:** _____

**How Did Symptom(s) Progress:** _____

**What Brings It On:** _____ **What Makes It Worse:** _____

**What Relieves It:** _____ **Associated Symptom(s):** _____

**Antibiotic Usage:** _____

**Comments:**

## MEDICATIONS - List all medications you are currently taking. Include ALL medications even the Over The Counter ones.

| Drug Name (Generic/Brand) | Dosage | Frequency | Status |
|---|---|---|---|
| | | | ❑ Current ❑ Chronic ❑ DC'd |
| | | | ❑ Current ❑ Chronic ❑ DC'd |
| | | | ❑ Current ❑ Chronic ❑ DC'd |
| | | | ❑ Current ❑ Chronic ❑ DC'd |
| | | | ❑ Current ❑ Chronic ❑ DC'd |

## ALLERGIES - List all allergies including any medications that caused an allergic reaction.

| List ALL Allergies | Allergic Reaction |
|---|---|
| | |
| | |
| | |

## Past Medical History - Please provide a complete history including all illnesses, injuries, hospitalizations and operations.

| List ALL illnesses, Injuries & Operations | Date | Hospital | Treatment | Physician | Response |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Last Chest X-Ray:_____ ❑ Normal ❑ Abnormal Last EKG:_____ |

## Family History - Please list all Blood Relatives with their current health status and any illnesses they have had or have.

| List Blood Relatives | Health Status | Age If Living | Age At Death | Cause Of Death | Illnesses |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| | | | | | |
| Sister(s) | | | | | |
| | | | | | |

**Mental Work:** ❑ Omit ❑ Light ❑ Moderate ❑ Heavy Hours Per Day:_____

**Physical Work:** ❑ Omit ❑ Light ❑ Moderate ❑ Heavy Hours Per Day:_____

**Exercise:** ❑ Omit ❑ Light ❑ Moderate ❑ Heavy Hours Per Day:_____Types of Exercise:_____

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**Alcohol:** ❑ Omit ❑ Never ❑ Beer(s)____Per Week ❑ Liquor____Per Week ❑ Wine____Per Week How Many Years:____

**Smoking:** ❑ Omit ❑ Never ❑ Current ❑ Previous Packs Per Day____ How Many Years____

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**Caffeine:** ❑ Omit ❑ None Cups Per Day_____ How Many Years:_____ Other:_____

**Aspirin:** ❑ Omit ❑ None Quantity Per Day_____ How Many Years:_____ Other:_____

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**Nutritional Information:** ❑ Low Sodium Diet ❑ Diabetic Diet ❑ Low Fat Diet ❑ Vegetarian Diet ❑ Low Cholesterol Diet ❑ Other:_____

**Miscellaneous Drugs:** ❑ Amphetamines ❑ Antacids ❑ Cocaine ❑ Diet Pills ❑ Laxatives ❑ Marijuana ❑ Nutrasweet ❑ Pain Pills ❑ Saccharin ❑ Sleeping Pills ❑ Vitamins ❑ Other:_____

First Name: _____ Middle: _____ Last Name: _____

## Review of Symptoms - Check only the Ones you NOW have or have had RECENTLY.

### General
- ❑ Weakness
- ❑ Fatigue
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Fainting
- ❑ None

### Skin
- ❑ Color Changes
- ❑ Nail Changes
- ❑ Hair Changes
- ❑ Moles
- ❑ Rashes
- ❑ Itchy Skin
- ❑ Sores
- ❑ Dryness
- ❑ None

### Head
- ❑ Headaches
- ❑ Injuries
- ❑ Bumps
- ❑ None

### Eyes
- ❑ Blurred Vision
- ❑ Glaucoma
- ❑ Redness
- ❑ Itching
- ❑ Burning
- ❑ Swelling
- ❑ Pain
- ❑ Dryness
- ❑ Tearing
- ❑ None

### Ears
- ❑ Hard of Hearing
- ❑ Deafness
- ❑ Ringing
- ❑ Discharge
- ❑ Earache
- ❑ Itching
- ❑ Loss of Balance
- ❑ Dizziness
- ❑ Room Spins
- ❑ None

### Nose
- ❑ Decreased Smell
- ❑ Bleeding
- ❑ Pain
- ❑ Discharge
- ❑ Obstruction
- ❑ Post Nasal Drip
- ❑ Deviated Septum
- ❑ Runny Nose
- ❑ Sinus Congestion
- ❑ None

### Mouth
- ❑ Bleeding Gums
- ❑ Sores
- ❑ Dental Problems
- ❑ Mouth Jaw Pain
- ❑ Bad Breath
- ❑ Loss of Taste
- ❑ Dryness
- ❑ Ulcers
- ❑ Blisters
- ❑ Bad Taste
- ❑ None

### Throat
- ❑ Sore Throat
- ❑ Bad Tonsils
- ❑ Hoarseness
- ❑ Pain
- ❑ Hard To Swallow
- ❑ Recurrent Infections
- ❑ White Spots
- ❑ None

### Neck
- ❑ Enlargement
- ❑ Stiffness
- ❑ Soreness
- ❑ Pain
- ❑ Lumps
- ❑ Masses
- ❑ None

### Lungs
- ❑ Cough
- ❑ Phlegm
- ❑ Coughed Blood
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Pain in Lungs
- ❑ Chest Congestion
- ❑ Inhalant Exposure
- ❑ None

### Heart
- ❑ Murmur
- ❑ Palpitations
- ❑ Rapid Heartbeat
- ❑ Swollen Extremities
- ❑ Cold Extremities
- ❑ Tightness/Pressure
- ❑ Chest Pains
- ❑ Varicose Veins
- ❑ Blood Clots
- ❑ Blue Extremities
- ❑ None

### Blood
- ❑ Broken Blood Vessels
- ❑ Anemia
- ❑ Easy Bruising
- ❑ Prolonged Bleeding
- ❑ Swollen Nodes
- ❑ Painful Nodes
- ❑ Red Dots/Spots
- ❑ None

### Gastrointestinal
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Bloatedness
- ❑ Belching
- ❑ Heartburn
- ❑ Indigestion
- ❑ Irregular Bowels
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Hernias
- ❑ Poor Appetite
- ❑ Food Intolerance
- ❑ Bloody Stools
- ❑ Black Tarry Stools
- ❑ Excessive Appetite
- ❑ Rectal Bleeding
- ❑ None

### Genitourinary
- ❑ Urgency
- ❑ Incontinence
- ❑ Straining
- ❑ Flank Pain
- ❑ Frequency
- ❑ Stones
- ❑ Burning
- ❑ Bed Wetting
- ❑ Bloody
- ❑ Small Stream
- ❑ Urethral Discharge
- ❑ Dribbling
- ❑ Cloudy Urine
- ❑ Unusual Color
- ❑ Urination at Night
- ❑ Hesitancy
- ❑ None

### Musculoskeletal
- ❑ Pain
- ❑ Weakness
- ❑ Cramps
- ❑ Twitching
- ❑ Joint Stiffness
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Joint Deformities
- ❑ Injuries
- ❑ Curvature of Spine
- ❑ Back Pain
- ❑ Hot Joint
- ❑ None

### Neurological
- ❑ Seizures
- ❑ Vertigo
- ❑ Hand Trembling
- ❑ Loss of Sensation
- ❑ Incoordination
- ❑ Loss of Facial Expressions
- ❑ Weak Grip
- ❑ Paralysis
- ❑ Slurred Speech
- ❑ Tingling/Burning/Numbing
- ❑ Loss of Memory
- ❑ Lack of Concentration
- ❑ Disorientation
- ❑ Gait Shuffling
- ❑ None

### Psychiatric
- ❑ Hyperventilation
- ❑ Insecurity
- ❑ Depression
- ❑ Insomnia
- ❑ Irritability
- ❑ Anxiousness/Stress
- ❑ Indecisiveness
- ❑ Timid/Shy/Bashful
- ❑ Hallucinations
- ❑ Alcohol Abuse
- ❑ Drug Use
- ❑ Suicidal Thoughts
- ❑ Worrying
- ❑ Obsessiveness
- ❑ Mania/Depression
- ❑ Multiple Personalities
- ❑ Sexual Difficulties
- ❑ Numbness
- ❑ Panic Attacks
- ❑ Compulsiveness
- ❑ None

### Endocrine
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Hoarseness
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Breast Changes
- ❑ Loss of Hair
- ❑ Extreme Thirst
- ❑ Voice Changes
- ❑ Excessive Hair
- ❑ Hypoglycemia
- ❑ Diabetes
- ❑ None

## Vital Signs

**Height:** _____ **Method:** ❑ Auricular ❑ Oral

**Weight:** _____ ❑ Axillary

**Temp:** _____ ❑ Forehead

**Resp:** _____ ❑ Rectal

| | B.P. | Pulse | Extremity | Comment |
|---|---|---|---|---|
| **Sitting:** | _____ | _____ | _____ | _____ |
| **Standing:** | _____ | _____ | _____ | _____ |
| **Supine:** | _____ | _____ | _____ | _____ |