

Cardiac Specialists

Cardiovascular Risk Assessment and Patient History form

Thank you for taking the time to fill out our health questionnaire. This will allow us to better serve your health needs. This is a confidential record of your medical history and will be kept in this office.

Today's date: _____ Name: _____ Date of Birth: _____

Primary Care Provider: _____

Problem Today (Describe any recent testing): _____

Current Medications and Dosages (If none please write None)

ALLERGIES (Drug, Food, environment) Please circle **No** or **Yes** (If Yes please list) _____

Past Medical History: (Please indicate "Y" for Yes or "N" for No, if uncertain write "?")

| | | | |
|--------------------------------------|-----------------------|------------------------------|------------------|
| ___ High Blood Pressure | ___ Diabetes | ___ High Cholesterol | ___ Heart Attack |
| ___ Heart Catheterization | ___ Angioplasty | ___ Congestive Heart Failure | ___ Stroke/TIA |
| ___ Valve problem/Heart murmur | ___ Rheumatic fever | ___ Loss of Consciousness | ___ Asthma |
| ___ Arrhythmia(irregular heart beat) | ___ Emphysema | ___ Pneumonia | ___ Anemia |
| ___ Vascular (blood vessel) Disease | ___ Bleeding tendency | ___ Ulcer | ___ Cancer |
| ___ Liver Disease/Hepatitis | ___ Kidney Disease | ___ Arthritis | ___ Glaucoma |
| ___ Migraine Headaches | ___ Thyroid Disease | ___ HIV Disease | |
| ___ Autoimmune Disease | ___ Other _____ | | |

Past Surgical History and Hospitalizations: (please list and give approximate dates) **If none please check here** _____

1. _____ 2. _____
3. _____ 4. _____

FAMILY MEDICAL HISTORY: **If no positive family history please check here** _____

Has any blood relative had any of the following (Please indicate "Y" for Yes or "N" for No, if uncertain write "?")
Please document the relationship(father, mother, sibling or other blood relative)

| | |
|-------------------------------|--|
| High Blood Pressure _____ | Sudden Death _____ |
| Diabetes _____ | Congestive Heart Failure _____ |
| High Cholesterol _____ | Arrhythmia(irregular heart beat) _____ |
| Heart Attack _____ | Vascular (blood vessel) Disease _____ |
| Angioplasty _____ | Cancer _____ |
| Coronary Bypass Surgery _____ | Other _____ |
| Stroke _____ | |

SOCIAL HISTORY: Marital status: M _____ S _____ D _____ W _____ Occupation: _____

Place of Birth _____ Children _____

Habits:

Smoking (Type & amt/day) _____ If former smoker, date quit _____

Alcohol (Type & amt/day) _____ Caffeine (Type and amt/day) _____

Street Drugs (Type and amt/day) _____

REVIEW OF SYSTEMS: (Please check "Yes or "No to ALL)

| <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> |
|--|--|---------------------------------|
| ___ ___ weight loss/gain | ___ ___ shortness of breath | ___ ___ headache |
| ___ ___ Weakness/ fatigue | ___ ___ cough | ___ ___ numbness / weakness |
| ___ ___ fever / night sweats | ___ ___ coughing up blood | ___ ___ off balance / dizziness |
| ___ ___ blurred / double vision | ___ ___ awake from sleep short of breath | ___ ___ seizure |
| ___ ___ chest pain/discomfort | ___ ___ nausea / vomiting / diarrhea | ___ ___ anxious |
| ___ ___ irregular heartbeats | ___ ___ heartburn / reflux | ___ ___ depressed |
| ___ ___ leg swelling | ___ ___ abdominal pain | ___ ___ bleeding tendency |
| ___ ___ palpitations | ___ ___ rectal bleeding | ___ ___ easy bruising |
| ___ ___ discomfort in the thighs/buttocks with activity or exercise | ___ ___ muscle weakness / pain | ___ ___ frequent infections |
| ___ ___ purple fingers or toes | ___ ___ joint pain / swelling | |
| | ___ ___ skin rash | |

Additional Information:

How would you describe your current state of health? _____

How would you describe your diet? _____

How often do you exercise? _____

Do you use alternative/complementary medicine? _____

Do you have an advance directive or living will? _____

Is there anything else we should know about you? _____

Patient Signature: _____ Physician Signature: _____

Physician use Only

Reviewed and updated at subsequent visits:

| Practitioner | Date | Practitioner | Date | Practitioner | Date |
|--------------|------|--------------|------|--------------|------|
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