

Cardiac Specialists, P.C.

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