

ADVANCED CARDIAC HEALTHCARE, PLC
HISTORY ASSESSMENT

Patient Name _____ Appointment Date _____

Why are you seeing a cardiologist?

Please fill out the "Patient" side of this form only.

PATIENT

CLINICIAN

Cardiac Symptoms:

Circle any of the following you have experienced:

- Heart Attack
- Chest Discomfort
- Shortness of Breath
- Arm, jaw, or back pain
- Palpitations
- Lightheadedness/dizziness
- Fainting/Passing out
- Swelling of arms, legs, and/or abdomen
- Recent sudden weight gain or loss
- Fatigue

Cardiac Procedures

Circle any of the following procedures you have had, listing the date of the procedure on the line provided:

- Cardiac stress test _____
- Echocardiogram _____
- Holter/Event Monitor _____
- Tilt table test _____
- Heart catheterization/angiogram _____
- Balloon angioplasty (PTCA) _____
- Stent _____
- Rotablator _____
- Electrophysiology study _____
- Ablation _____
- Pacemaker/ICD implant _____
- Coronary Artery Bypass surgery _____
- Valve Surgery _____
- Cholesterol Check _____

Surgical History

List types of surgeries you have had: What year?

List types of surgeries you have had:	What year?

Will you be having surgery in the near future? Y N What type? _____

Who will the surgeon be? _____

Past Medical History

Patient

Clinician

Cardiac Risk Factors

Please circle any of the following risk factors you have:

High Blood pressure

High cholesterol

Diabetes

High stress

Obesity

Please circle any other medical problems you have been diagnosed with:

Rheumatic fever

Emphysema

Stroke/TIA

Kidney disease

Prostate problems

Gallbladder disease

Liver disease/hepatitis

Chronic lung disease

Tuberculosis

Asthma

Cancer

Arthritis

Glaucoma/Cataracts

Thyroid disorder

HIV

Blood clots

Other _____

Social History:

Do you smoke? Y N If no, have you ever? Y N When did you stop? _____

How much did/do you smoke? _____ For how long? _____

How much alcohol do you drink? _____ For how long? _____

Do you use recreational drugs? Y N If no, did you ever? Y N

If yes, please list type and frequency _____

Do you exercise? Y N How frequently?

Do you eat a low-fat diet? Y N Low sodium? Y N Low sugar? Y N

What is your occupation? _____

Patient Name _____ DOB _____

Family History:

Please answer Y or N to the following, as well as listing the age of each individual in the appropriate column:

	Alive?	Age now or when deceased	Heart Attack	Congestive Heart Failure	Diabetes	High Blood Pressure	High Cholesterol	Other Heart Problems
Father								
Mother								
Sibling								
Sibling								
Sibling								
Grandfather								
Grandmother								

Review of systems:

Please circle any of the following symptoms you have experienced:

Lack of energy, trouble sleeping, loss of appetite, fevers
Eye problems, double vision, blurred vision
Hearing problems, buzzing or ringing in ears
Allergies, hay fever
Sinus problems
Breathing problems, wheezing, cough, coughing up blood difficulty breathing while lying flat, excessive daytime sleep- iness, waking suddenly at night with shortness of breath
Stomach problems, indigestion, change in bowel habits
Bloody or tarry stools, ulcers, jaundice
Changed frequency of urination, urinary tract infections incontinence, gall stones Men: night-time urination Women: abnormal menstrual cycles, current pregnancy
Joint pain, swelling or redness, back pain
Muscle aches or tenderness
Rash, itching, other skin problems
Women: breast lumps, abnormal mammogram, abnormal pap smear, abnormal pelvic exam
Paralysis (even temporary), numbness, loss of balance
Seizures, loss of memory, headaches
Unusual thoughts, nervousness, crying or sadness, depression
Suicide attempts
Excessive thirst, hunger, or urination
Unusual bleeding, easy bruising

