Name: _____

Date of Visit _____ **Primary Care Provider** _____

Date of Birth _____ **Age** _____ **Reason for Visit** _____

Personal Medical History

1. **Coronary artery disease** ☐ yes ☐ no
   Heart attack? When _____
   Bypass surgery? When _____
   Angioplasty/stent? When _____
2. **Heart valve disease** ☐ yes ☐ no _____
3. **Heart failure** ☐ yes ☐ no _____
4. **High blood pressure** ☐ yes ☐ no _____
5. **High Cholesterol** ☐ yes ☐ no _____
6. **Peripheral Vascular Disease** ☐ yes ☐ no _____
7. **Blood Vessel Surgery** ☐ yes ☐ no
   When? _____
8. **Stroke** ☐ yes ☐ no; When? _____
9. **Diabetes** ☐ yes ☐ no; How long? _____
10. **Surgeries** _____
    _____
11. **Hospitalizations** _____
    _____

Family Medical History

1. **Coronary artery disease:**
   Family members with heart attacks? Who _____ How old were they? _____
   Family members with bypass surgery? Who _____ How old were they? _____
2. **Health Status of Relatives**
   Father: ☐ alive ☐ deceased; Health problems: _____
   Mother: ☐ alive ☐ deceased; Health problems: _____
   Siblings: How many? _____ Health problems _____

Social History/Personal Habits

1. **Do you smoke?** ☐ yes ☐ no ☐ quit (when:_____) How many packs?_____ How many years? _____
2. **Do you drink alcohol?** ☐ yes ☐ no; How much, how often? _____
3. **Do you drink caffeine?** ☐ yes ☐ no; How much, how often? _____
4. **Do you use recreational drugs?** ☐ yes ☐ no; What drug?_____How often? _____
5. **Marital Status?** ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed ☐ partnered
6. **Children?** ☐ yes ☐ no; Boys _____ Girls _____ Health problems: _____
7. **Occupation:** _____
8. **Exercise routine:** Type of exercise:_____How often? _____

Organ Systems Review

General
☐ Change in weight
☐ Visual problems
☐ Hearing problems

Psychiatric
☐ Anxiety
☐ Depression

Endocrine
☐ Thyroid Disease

Neurologic
☐ Seizures

Gynecological
☐ Hysterectomy
☐ Post-menopause

Pulmonary
☐ Cough
☐ Asthma
☐ Shortness of breath
☐ Emphysema
☐ Breathing problems at night

Cardiac
☐ Palpitations
☐ Passing out
☐ Chest discomfort

Skin
☐ History of cancer
☐ Rashes

Urinary
☐ Pain in urination
☐ Prostate problems
☐ Kidney disease

Gastrointestinal
☐ History of ulcers
☐ History of hepatitis
☐ Blood in stools
☐ Black, tarry stools

Hematologic
☐ Bleeding abnormalities
☐ Clotting abnormalities

Musculoskeletal
☐ Arthritis
☐ Autoimmune disease (lupus, rheumatoid arthritis)

Vascular
☐ Claudication (leg pain with walking)

Other Comments: _____
_____
_____

PATIENT IDENTIFICATION

BARTON MEMORIAL HOSPITAL
CARDIOLOGY
NEW PATIENT HISTORY FORM & PHYSICAL

1/13/12
B045 / 7561-E002
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