



Medical History Form

E4

Name _____

Date of Birth _____ Primary Phys _____

HT: _____ WT: _____ Today's Date _____

Cardiovascular History:

- Heart Attack (MI)
- Coronary Artery Disease
- High Blood Pressure
- Stroke/Mini-stroke
- Heart Murmur
- Heart Valve Problem
- Rheumatic Fever
- Heart Failure
- Arrhythmia
- Angioplasty/Stent
- Bypass Surgery
- Pacemaker

- Defibrillator/ICD
- Chest Pain/Discomfort
- Angina
- Fainting/Black-outs
- Lightheaded/Dizziness
- Palpitations
- Short of Breath
- Swelling in Feet/Hands
- Blood Vessel Disease:
 - In Legs
 - In Neck
 - In Kidneys

Social History:

- Married Widowed Divorced
- Children Minor/Adult
- Live Alone
- Live with Spouse
- Live with Other _____
- Occupation _____
- Retired or Unemployed
- Caffeine Amount _____
- Alcohol Amount _____
- Drug use _____
- Regular Exercise _____
- Diet Type _____

Previous Cardiac Testing:

- Heart Cath
- Angioplasty/Stent
- Bypass Surgery
- Stress Test
- Echocardiogram
- Holter/Event Monitor
- Dopplers of Blood Vessels
- Hospitalization for Heart

Where:

When:

Coronary Risk Factors:

- High Cholesterol
- Diabetes
- How long _____ Insulin
- Overweight
- High Blood Pressure
 - How long _____
- Smoking History:
 - Previous Smoker
 - Current Smoker
 - Cigarettes
 - Pipe
 - Cigars
 - Other _____
- How many packs daily _____
- How many years _____
- Previous/current second-hand smoke exposure

Family History: (circle if yes)

- Heart disease/Heart failure/
- High blood pressure/Diabetes
- Stroke/ Kidney disease
- Father-alive/deceased age _____
- Cause of death _____
- Mother-alive/deceased age _____
- Cause of death _____
- Brothers- alive/deceased _____
- Age/Cause of death _____
- Sisters- alive/deceased _____
- Age/cause of death _____

Recent Hospitalization:

History of Trauma/Accidents:

History of Unusual Illness:

Previous Surgery:

Where:

When:

Medical History Form (cont'd):

Name _____

DOB _____

Michigan Cardiovascular
Institute

REVIEW of SYSTEMS

General:

- Fatigue
- Weakness
- Fever
- Chills
- Appetite Change
- Weight Change
- Abnormal Sweating

Neurological:

- Migraines
- Seizures
- Numbness
- Tremors
- Dizziness
- Lightheadedness
- Headaches
- Memory Problems
- Falls
- Other _____

Psychiatric:

- Diagnosis of:
 - Bi-Polar disorder
 - Schizophrenia
 - Obsessive/Compulsive
- Depression
- Anxiety
- Mood swings
- Panic Attacks
- Personality changes

HEENT:

- Glaucoma
- Cataracts
- Macular Degeneration
- Corrective lens use
- Blurred vision
- Visual field defect
- Hearing Problems
- ringing in Ears
- Hearing Aids
- Sinus Problems
- Nosebleeds
- Voice changes
- Recurrent sore throat
- Other _____

Cancer of: _____

- Chemotherapy
- Radiation Therapy
- Port Placement
- Radiation Implants

Pulmonary:

- Chronic lung disease
- Asthma
- Emphysema
- Bronchitis
- Pneumonia
- TB
- Sleep Apnea
- Blood Clot in Lung
- Short of Breath:
 - With Activity only
 - At Rest
 - At Night
- Smoking History
- Wheezing
- Cough:
 - Non-productive/dry
 - Productive
- Inhaled chemicals/dust
- Other _____

Gastrointestinal:

- Hiatal Hernia
- Reflux
- Ulcers/Gastritis
- Hernia
- Colitis/Crohn's
- Diverticulitis
- Gall Bladder disease
- Hepatitis
- Cirrhosis
- Pancreatitis
- Heartburn/indigestion
- Nausea
- Vomiting
- Trouble swallowing
- Chronic diarrhea
- Chronic constipation
- Blood in Stool
- Yellow Jaundice
- Other _____

Genitourinary:

- Kidney Failure
- Kidney stones
- Kidney/bladder infection
- Dialysis
- Prostate Problems
- Disease of ovaries/uterus
- Breast disease
- Blood in Urine
- Pain when urinating
- Frequent urination
- Urination at night

Endocrine:

- Thyroid disease
- Diabetes
- "Borderline" Diabetes
- Insulin Use
- Heat intolerance
- Cold intolerance
- Increased thirst
- Increased hunger

Heme/Lymph:

- Anemia
- Bleeding problems
- Clotting problems
- Transfusions
- Leukemia/lymphoma
- Blood clot in leg/lung
- Easy bruising
- Lymph node swelling
- Lymph node pain

Skin:

- Psoarisis
- Rashes
- Itching

Musculoskeletal:

- Osteoarthritis
- Rheumatoid Arthritis
- Gout
- Fractures
- Joint pain
- Back Problems
- Muscle disease
- Extremity weakness
- Cane/Walker use
- Wheelchair use
- Other _____

Current Medications:

ALLERGY to medications:

Reviewed by: _____

Nurse's signature

Reviewed by: _____ MD