



**ADVANCED  
CARDIOVASCULAR  
SPECIALISTS**

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## **CARDIOVASCULAR HISTORY**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

1. **CHIEF COMPLAINT:** (What is the major symptom or problem that brought you to the office? Date of onset?)



2. When did symptoms first occur? \_\_\_\_\_
3. Where does the pain/symptom start? \_\_\_\_\_
4. How long did the 1<sup>st</sup> episode last? \_\_\_\_\_
5. On a scale of 1 to 10 (with 10 being the worst), what level would you say your pain/symptom is? \_\_\_\_\_  
\_\_\_\_\_
6. Does the pain spread around or travel straight through? \_\_\_\_\_
7. How long does symptom last? \_\_\_\_\_
8. What is the timing of the symptom? (Ex. sudden onset, gradual onset, night, morning, upon awakening, during day, while sleeping, stress, etc.) \_\_\_\_\_
9. Does anything in particular bring the symptom on? (Ex: exercise, emotions, eating, sleep, sex, etc.) \_\_\_\_\_  
\_\_\_\_\_
10. Aggravating factors: \_\_\_\_\_
11. What gives relief? \_\_\_\_\_
12. When the symptom occurs, are there any other symptoms at the same time? (Ex: nausea, vomiting, shortness of breath, palpitations, faintness, numbness, etc.) \_\_\_\_\_
13. Have you ever seen a Cardiologist before? \_\_\_\_\_  
If so, what was the Cardiologist's name and address? \_\_\_\_\_  
\_\_\_\_\_
14. Have you ever been diagnosed with a heart condition at ANY time in the past? \_\_\_\_\_  
If so, what were you diagnosed as having? \_\_\_\_\_
15. Do you have pain in legs when walking? \_\_\_\_\_





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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### SOCIAL HISTORY

1. Do you smoke? \_\_\_\_Yes \_\_\_\_No Packs per day \_\_\_\_\_ No. of years \_\_\_\_\_  
Discontinued smoking \_\_\_\_ Yes \_\_\_\_No How long ago? \_\_\_\_\_
  
2. Alcohol intake? \_\_\_\_\_Never \_\_\_\_\_Occasionally \_\_\_\_\_Socially  
\_\_\_\_Beer \_\_\_\_\_Wine \_\_\_\_\_Other  
How often? \_\_\_\_\_Daily \_\_\_\_\_Weekly \_\_\_\_\_Monthly
  
3. Diet: No Particular diet \_\_\_\_\_ Low Fat/Low Cholesterol \_\_\_\_\_  
Moderate Fatty diet \_\_\_\_\_ High fatty diet \_\_\_\_\_ Diabetic Diet \_\_\_\_\_
  
4. Lifestyle: \_\_\_\_Single \_\_\_\_Married \_\_\_\_Widowed \_\_\_\_Divorced \_\_\_\_Other
  
5. Exercise: (walking, running, weights, working out in gym, etc.) \_\_\_\_\_  
Frequency \_\_\_\_\_ How many times/week \_\_\_\_\_ How many times/month \_\_\_\_\_
  
6. Average amount of Sleep per night: (Hours) \_\_\_\_\_
  
7. Education: High school education \_\_\_\_\_ College \_\_\_\_\_ Degree \_\_\_\_\_
  
8. Occupation: \_\_\_\_\_
  
9. Spouse's Occupation: \_\_\_\_\_



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Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## MEDICAL HISTORY

| <u>General</u>                             | YES | NO  |
|--|-----|-----|
| Weight change                              | [ ] | [ ] |
| Fever/chills                               | [ ] | [ ] |
| Night sweats                               | [ ] | [ ] |
| <u>Endocrine System</u>                    |     |     |
| Heat/cold intolerance                      | [ ] | [ ] |
| Thyroid problems                           | [ ] | [ ] |
| Family history of thyroid problems         | [ ] | [ ] |
| Family history of diabetes                 | [ ] | [ ] |
| Neck surgery                               | [ ] | [ ] |
| <u>Eyes</u>                                |     |     |
| Vision problems                            | [ ] | [ ] |
| Glasses or contacts                        | [ ] | [ ] |
| Eye surgery (cataracts)                    | [ ] | [ ] |
| <u>Ear, Nose &amp; Throat</u>              |     |     |
| Difficulty hearing/deaf                    | [ ] | [ ] |
| Ringling in ears                           | [ ] | [ ] |
| Nose bleeds                                | [ ] | [ ] |
| Hoarseness                                 | [ ] | [ ] |
| Sinusitis                                  | [ ] | [ ] |
| Vertigo                                    | [ ] | [ ] |
| <u>Pulmonary System</u>                    |     |     |
| YES  |     |     |
| NO   |     |     |
| Dyspnea/breathlessness/shortness of breath | [ ] | [ ] |
| Cough/sputum production                    | [ ] | [ ] |
| Blood in sputum                            | [ ] | [ ] |
| Wheezing asthma                            | [ ] | [ ] |
| Tuberculosis/TBC exposure                  | [ ] | [ ] |
| Respiratory infections                     | [ ] | [ ] |
| Pneumonia                                  | [ ] | [ ] |
| Environmental inhalation                   | [ ] | [ ] |



Gastrointestinal System

|                       |     |     |
|-----------------------|-----|-----|
| Nausea/retching       | [ ] | [ ] |
| Vomiting              | [ ] | [ ] |
| Vomiting blood        | [ ] | [ ] |
| Difficulty swallowing | [ ] | [ ] |
| Indigestion           | [ ] | [ ] |
| Heartburn             | [ ] | [ ] |
| Abdominal pain        | [ ] | [ ] |
| Abdominal swelling    | [ ] | [ ] |
| Jaundice              | [ ] | [ ] |
| Red blood in stool    | [ ] | [ ] |
| Black stool           | [ ] | [ ] |
| Diarrhea              | [ ] | [ ] |
| Constipation          | [ ] | [ ] |
| Hiatal Hernia         | [ ] | [ ] |
| Inguinal Hernia       | [ ] | [ ] |
| Hemorrhoids           | [ ] | [ ] |
| Peptic ulcer disease  | [ ] | [ ] |
| Gallbladder disease   | [ ] | [ ] |
| Pancreatitis          | [ ] | [ ] |
| Hepatitis             | [ ] | [ ] |

Genitourinary System

|                                 |     |     |
|---------------------------------|-----|-----|
| Urinary frequency               | [ ] | [ ] |
| Urinary urgency                 | [ ] | [ ] |
| Pain on urination               | [ ] | [ ] |
| Urinate _____ times at night    |     |     |
| Blood in urine                  | [ ] | [ ] |
| Urinary stream flow abnormality | [ ] | [ ] |
| Hesitancy/intermittency         | [ ] | [ ] |
| Urinary incontinence            | [ ] | [ ] |
| Urinary tract infections        | [ ] | [ ] |
| Flank pain                      | [ ] | [ ] |
| Kidney stones                   | [ ] | [ ] |

Skin

|                    |     |     |
|--------------------|-----|-----|
| Itching            | [ ] | [ ] |
| Rash               | [ ] | [ ] |
| Change in mole (s) | [ ] | [ ] |
| Skin cancer        | [ ] | [ ] |
| Other              | [ ] | [ ] |



Neurological System

|                           |     |     |
|---------------------------|-----|-----|
| Headaches                 | [ ] | [ ] |
| Epileptic seizures        | [ ] | [ ] |
| Dizziness, blurred vision | [ ] | [ ] |
| Numbness or tingling      | [ ] | [ ] |
| Weakness                  | [ ] | [ ] |
| Head Trauma               | [ ] | [ ] |
| Stroke                    | [ ] | [ ] |
| Other                     | [ ] | [ ] |

Hematopoietic System

|                               |     |     |
|-------------------------------|-----|-----|
| Excessive bleeding            | [ ] | [ ] |
| Excessive bruising            | [ ] | [ ] |
| Anemia                        | [ ] | [ ] |
| Family history of sickle cell | [ ] | [ ] |

Musculoskeletal System

|                 |     |     |
|-----------------|-----|-----|
| Joint stiffness | [ ] | [ ] |
| Joint pain      | [ ] | [ ] |
| Joint swelling  | [ ] | [ ] |
| Arthritis       | [ ] | [ ] |

Psychiatric

|  |     |     |
|--|-----|-----|
| Psychiatric problems or hospitalizations | [ ] | [ ] |
| Interpersonal relationship difficulties  | [ ] | [ ] |
| Anxiety                                  | [ ] | [ ] |
| Depression                               | [ ] | [ ] |
| Loss of control/violence potential       | [ ] | [ ] |
| Substance abuse                          | [ ] | [ ] |



**Do you know of any blood relative who has or had: (Circle and give relationship)**

|                              |                            |                         |                           |
|------------------------------|----------------------------|-------------------------|---------------------------|
| Stroke _____                 | Epilepsy _____             | Heart Attack _____      | Nervous breakdown _____   |
| Cancer _____                 | Suicide _____              | Stomach<br>Ulcers _____ | Rheumatic<br>fever _____  |
| High Blood<br>Pressure _____ | Migraine _____             | Kidney<br>Disease _____ | Insanity _____            |
| Diabetes _____               | Asthma _____               | Goiter _____            | Congenital<br>Heart _____ |
| Leukemia _____               | Hayfever _____             | Arthritis _____         |                           |
| Tuberculosis _____           | Bleeding<br>Tendency _____ | Colitis _____           |                           |

**CURRENT MEDICATIONS**

**(Please list ALL medicines currently taken including: aspirin, vitamins, over-the-counter, herbal, etc.)**

| Name of Drug | Strength | Instructions | Prescribing physician |
|--------------|----------|--------------|-----------------------|
| 1. _____     | _____    | _____        | _____                 |
| 2. _____     | _____    | _____        | _____                 |
| 3. _____     | _____    | _____        | _____                 |
| 4. _____     | _____    | _____        | _____                 |
| 5. _____     | _____    | _____        | _____                 |
| 6. _____     | _____    | _____        | _____                 |
| 7. _____     | _____    | _____        | _____                 |
| 8. _____     | _____    | _____        | _____                 |
| 9. _____     | _____    | _____        | _____                 |
| 10. _____    | _____    | _____        | _____                 |
| 11. _____    | _____    | _____        | _____                 |
| 12. _____    | _____    | _____        | _____                 |
| 13. _____    | _____    | _____        | _____                 |
| 14. _____    | _____    | _____        | _____                 |
| 15. _____    | _____    | _____        | _____                 |
| 16. _____    | _____    | _____        | _____                 |





## PAST MEDICAL HISTORY

{Please list any problems you may have had in the past}

**HEENT:** (Head, eyes, ears, nose & throat) \_\_\_\_\_

**RESPIRATORY:** (Chronic Lung disease, pneumonia, etc.) \_\_\_\_\_

**HEART:** \_\_\_\_\_

a. Stroke \_\_\_\_\_ c. Thrombophlebitis \_\_\_\_\_

b. Heart murmur \_\_\_\_\_ d. Congestive Heart Failure \_\_\_\_\_

**BONE & JOINT:** \_\_\_\_\_

**SKIN:** \_\_\_\_\_

**NEUROLOGICAL:** \_\_\_\_\_

**PSYCHIATRY:** \_\_\_\_\_

**ENDOCRINE:** \_\_\_\_\_

**VASCULAR:** \_\_\_\_\_

**GASTROINTESTINAL:** \_\_\_\_\_

**GENITOURINARY:** \_\_\_\_\_

**HEMATOLOGY:** (Anemia, blood disorders, etc.) \_\_\_\_\_

Have you ever been diagnosed as having **HIGH CHOLESTEROL?** \_\_\_\_\_

Have you ever been diagnosed as having **DIABETES?** \_\_\_\_\_

Have you ever been diagnosed as having **HYPERTENSION?** \_\_\_\_\_

Have you ever been diagnosed as having **RHEUMATIC FEVER?** \_\_\_\_\_