Horizon Cardiology

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New Patient History Form

NAME OF PATIENT: _____ DATE: _____
LAST FIRST M.I.

AGE: _____ DATE OF BIRTH: _____ SEX: M / F HEIGHT: _____FT., _____IN., WEIGHT: _____lbs.

PHARMACY NAME: _____ **ADDRESS:** _____ **CITY:** _____

STATE: _____ **ZIPCODE:** _____ **PHONE NUMBER:** _____

ARE YOU ALLERGIC TO:	**YES**	**NO**	Please list allergies to medications and other substances. Describe reaction they cause.
ANY MEDICATIONS	Y	N	
IODINE, FISH OR SHELLFISH	Y	N	
X-RAY DYE OR IV CONTRAST	Y	N	
CAN YOU TOLERATE ASPIRIN	Y	N	

HAVE YOU TAKEN ASPIRIN OR ASPIRIN LIKE PRODUCT IN THE LAST 10 DAYS? (MOTRIN, ADVIL, NUPRIN) ☐ YES ☐ NO

IF YES, WHAT MEDICATION DID YOU TAKE? _____ WHEN DID YOU TAKE IT? _____

ARE YOU ON A SPECIAL DIET? ☐ YES ☐ NO IF YES PLEASE DESCRIBE: _____

CURRENT MEDICATIONS (Prescription & Non-prescription)	**DOSE** (Strength)	**SCHEDULE** (How many & times per day)	**HOW LONG HAVE YOU TAKEN?**
EXAMPLE: Cardizem	60 mg	1 pill, 4 times a day	1 Month

DO YOU HAVE:	**YES**	**NO**
HIGH BLOOD PRESSURE	Y	N
DIABETES CONTROLLED WITH	Y	N
☐ INSULIN ☐ PILL ☐ DIET		
HOW LONG: _____		
HISTORY OF SMOKING	Y	N
HIGH CHOLESTEROL		
FAMILY HISTORY OF HEART OR VASCULAR DISEASE	Y	N
A SEDENTARY OR INACTIVE LIFESTYLE	Y	N
WEIGHT CONTROL PROBLEMS (OBESITY)	Y	N
A STRESSFUL LIFE OR LIFESTYLE	Y	N
HISTORY OF RHEUMATIC FEVER OR SCARLET FEVER	Y	N

DO YOU NOW OR HAVE YOU EVER SMOKED TOBACCO PRODUCTS? ☐ YES ☐ NO

CIGARETTES:# OF PACKS PER DAY: _____ # OF YEARS: _____

CIGARS:# PER DAY: _____ # OF YEARS: _____

PIPE:# OF BOWLS PER DAY: _____ # OF YEARS: _____

WHEN WAS YOUR LAST CIGARETTE, CIGAR OR PIPE? _____

DO YOU DRINK ALCOHOL ON A REGULAR BASIS? ☐ YES ☐ NO

IF NO, DID YOU DRINK HEAVILY IN THE PAST? ☐ YES ☐ NO

IF YES, HOW MUCH DO YOU TYPICALLY DRINK IN ONE WEEK? _____

WHEN WAS YOUR LAST DRINK: _____

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

HAVE YOU EVER BEEN TREATED FOR SUBSTANCE ABUSE ☐ YES ☐ NO

PLEASE COMPLETE OTHER SIDE

HAVE YOU EVER HAD ANY OF THE FOLLOWING	YES	NO	DATE OR YEAR	PLACE (HOSPITAL OR CITY)	COMPLICATIONS/PROBLEMS
EXAM BY A CARDIOLOGIST (HEART DOCTOR)					
HEART CATHETERIZATION OR ANGIOGRAM					
CORONARY ANGIOPLASTY (PTCA/BALLOON/STENT)					
EXERCISE TRESS TEST (TREADMILL)					
ECHOCARDIOGRAM (ULTRASOUND OF THE HEART)					
PACEMAKER					

PREVIOUS OPERATIONS/PROCEDURES	YEAR	SURGEON	PLACE (HOSPITAL OR CITY)	COMPLICATIONS/PROBLEMS

REASONS FOR OTHER HOSPITALIZATIONS (NON-SURGICAL ADMISSIONS)	YEAR	PHYSICIAN	PLACE (HOSPITAL OR CITY)

PLEASE LIST ANY OTHER MEDICAL ILLNESSES, ANY HISTORY OF CANCER OR CHRONIC CONDITIONS	HOW LONG HAVE YOU HAD THIS

IF YOU ARE SCHEDULED FOR SURGERY OR A HOSPITAL STAY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

HAVE YOU OR ANY BLOOD RELATIVES HAD ANY PROBLEMS WITH ANESTHESIA ☐ YES ☐ NO

IF YES, DESCRIBE: _____

Review of Systems

Please Check any symptoms you have now or have had in the past

PATIENT NAME: _____

SKIN
- ☐ Rashes, psoriasis or dermatitis
- ☐ Non-healing sores or skin ulcerations

EYES
- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Permanent blindness in either eye
- ☐ Cataracts
- ☐ Glaucoma

HEART
- ☐ Heart attack
  What year(s)? _____
- ☐ Chest discomfort / angina with physical activity
- ☐ Chest discomfort / angina at rest
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath at rest
- ☐ Awakening at night gasping for air or short of breath
- ☐ Require more than one pillow at night to breathe well
- ☐ Heart failure or "fluid on lungs"
- ☐ Palpitations, racing or pounding heart beat
- ☐ Pauses in the heart beat
- ☐ Previously diagnosed heart rhythm disturbance
- ☐ Heart murmur
- ☐ Mitral valve prolapse

BLOOD
- ☐ Bleeding or bruising tendency
- ☐ Blood disorder
  Specify _____
- ☐ Previous blood transfusion
- ☐ Recent fever
- ☐ History of hepatitis or other communicable disease

EARS / NOSES / THROAT
- ☐ Loss of hearing
  (Hearing aids? ☐ Yes ☐ No)
- ☐ Ringing in the ears
- ☐ Frequent ear infections or discharge
- ☐ Frequent or severe nose bleeds
- ☐ Nasal Polyps
- ☐ Frequent sinus infections
- ☐ Frequent sore throats
- ☐ Dentures
- ☐ Loose teeth

CIRCULATION

	RIGHT	LEFT	BOTH	
☐ Discoloration of feet or legs	R	L	B	
☐ Awaken at night with pain or numbness in feet	R	L	B	
☐ Pain in legs or buttocks with exercise	R	L	B	
☐ Sores or ulcers on feet or legs	R	L	B	
☐ Infection of feet or legs	R	L	B	
☐ Blood clot in leg vein	R	L	B	
☐ Blood clot in artery				
☐ Ankle or leg swelling	R	L	B	
☐ Phlebitis of leg veins				
☐ Large, discolored or varicose veins in legs	R	L	B	Painful ☐ No pain ☐
	R	L	B	
☐ Temporary blindness in either eye	R	L	B	
☐ Sudden visual disturbances in either eye	R	L	B	Painful ☐ No pain ☐
☐ Weakness or paralysis of one side of the body	R	L	B	
☐ Temporary speech loss or difficulty talking	R	L	B	
☐ "Mini-strokes" or TIAs				
☐ Stroke				
☐ Dizziness, light-headedness or "black out spells"				
☐ Aneurysm of any blood vessels				
☐ Throbbing or pulsating sensation in abdomen				
☐ Abdominal pain				
☐ Back or flank pain				

LUNGS
- ☐ Asthma or wheezing
- ☐ Recent bronchitis or chest cold
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Exposure to asbestos
- ☐ Blood clot (embolus) to lungs

PLEASE COMPLETE OTHER SIDE

STOMACH / INTESTINES

- ☐ Stomach ulcer or peptic ulcer
- ☐ Trouble swallowing foods or liquids
- ☐ Frequent heartburn or indigestion
- ☐ Hiatal hernia and/or reflux
- ☐ Liver disease or jaundice
  What year? _____
- ☐ Gall bladder attacks
- ☐ Frequent diarrhea
- ☐ Chronic constipation
- ☐ Bright blood from bowels or rectum
- ☐ Dark, tarry stools

NERVOUS SYSTEM

- ☐ Frequent headaches or migraines
- ☐ Epilepsy or seizures
  Date of last seizure_____
- ☐ Depression
- ☐ Nervous disorder
  Specify:_____

KIDNEYS / URINARY TRACT

- ☐ Kidney disease or failure
- ☐ History of kidney dialysis (What year?_____)
- ☐ Kidney stones or infection
- ☐ Pain or burning with urination
- ☐ Trouble starting urinary stream
- ☐ Dribbling or incontinence
- ☐ Multiple trips to bathroom to urinate at night
- ☐ Bladder infections during past year
- ☐ Blood in urine during past year
- ☐ Enlarged prostate
- ☐ Prostate infections

METABOLISM / ENDOCRINE

- ☐ Thyroid disorder
- ☐ Gout
- ☐ Recent weight gain or loss (>10 lbs.)

MUSCLES / BONES / JOINTS

- ☐ Arthritis or other joints disease
- ☐ Chronic back trouble
- ☐ History of broken bones:
- ☐ TMI syndrome
- ☐ Curvature of the spine (scoliosis)

REPRODUCTIVE (for Woman)

Are you or might you be pregnant?
☐ Yes ☐ No

Date (or yr.) of last period: _____

REPRODUCTIVE (for Men)

Have you had a vasectomy?
☐ Yes ☐ No

ACTIVITY LEVEL – Which of the following describes your level of physical activity both in your daily life and your leisure time

- ☐ Exercise strenuously on a regular basis
- ☐ Exercise moderately on a regular basis
- ☐ Exercise on an occasional basis
- ☐ Do not regularly exercise, but have an active lifestyle
- ☐ Have difficulty accomplishing light chores of daily living
- ☐ Require assistance to accomplish self-care.

FAMILY HISTORY – Please list which family members (blood relatives) have experienced these conditions

Heart Attack: _____ age: ____
_____ age: ____
_____ age: ____
Stroke: _____ age: ____
_____ age: ____
_____ age: ____
Sudden Death: _____ age: ____
_____ age: ____

Aneurysm: _____
Diabetes: _____
Cancer: _____
High Blood Pressure: _____
High Cholesterol: _____
Heart Failure: _____
Arteriosclerosis: _____
(hardening of the arteries)

If your parents are deceased, please indicate the cause of death and age of death:

Father: _____ Age: _____

Mother: _____ Age: _____

Do you have any other special concerns or additional information we should be aware of regarding your care?: _____

_____

_____

Please sign below after you have completed this form to the best of your ability and knowledge:

Signature: _____ Date: _____