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Patient Focused • Quality Oriented • Physician Driven

### Cardiology History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Medical History:** Please check any of the conditions that represent a SIGNIFICANT problem for you

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain with activity		Burning or painful urination	
Recent weight change		Heart skips beats		Frequent urination	
Fatigue		Heart beats too fast		Blood in urine	
Heat or cold intolerance		Passing out spells		Bladder infections	
<b>Head and Neck</b>	<b>YES</b>	High blood pressure		Incontinence, dribbling	
Swelling in neck		Heart murmur		Kidney stones	
Prolonged hoarseness		Bad heart valve		Change in stream	
Sore throat		Rheumatic Fever		Irregular menses, female only	
Pain or stiffness in neck		Feet or ankle swelling		<b>Gastrointestinal</b>	<b>YES</b>
<b>Skin</b>	<b>YES</b>	Short of breath at rest		Rectal bleeding	
Rash, dryness, itching		Short of breath with exercise		Blood in stool	
Change in nails or skin color		Short of breath lying down		Loss of appetite	
Bleeding, bruising tendencies		<b>Lungs</b>	<b>YES</b>	Heartburn or indigestion	
<b>Eyes</b>	<b>YES</b>	Cough		Chronic abdominal pain	
Glasses or contacts		Cough with sputum or blood		Chronic constipation	
Double, failing vision		Wheezing		Black or tarry stools	
Dry eyes		<b>Musculoskeletal</b>	<b>YES</b>	Frequent diarrhea	
Pain or light sensitivity		Swollen or red joints		Difficulty swallowing	
<b>Ears, Nose, Mouth</b>	<b>YES</b>	Arm or leg weakness		Nausea or vomiting	
Loss of smell		Leg cramps		Vomiting of blood	
Nose bleeds		Difficulty in walking		<b>Endocrine</b>	<b>YES</b>
Sinus problems		<b>Neurologic</b>	<b>YES</b>	Night sweats	
Runny nose		Light headed or dizziness		Excessive thirst	
Postnasal drip		Speech disturbances		<b>Psychiatric</b>	<b>YES</b>
Earache or drainage		Convulsions or seizures		Depression	
Hearing loss		Numbness or tingling		Anxiety	
Ringing in ears		Frequent headaches		Nervous breakdown	
Dentures		Memory loss		Alcohol problems	
Sores in mouth		Paralysis or weakness		Physical, verbal, sexual abuse	
		Sleep disorders		Drug problems	

**Past and Family Medical History:** Please check if you or your family have ever had any of the following

	You	Family		You	Family		You	Family
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Blood Disorders			Vision Problems		
Renal Disease			Lupus			Hearing Problems		
Ulcerative Colitis			Stroke			Glaucoma		
Other			Other			Other		

