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CONFIDENTIAL MEDICAL HISTORY

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CARDIOVASCULAR DISEASES - SPORTS CARDIOLOGY

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

DATE OF BIRTH: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

ENCINITAS, CA 92024

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space. Please leave no blanks. No part of this form's contents will be released without your signed consent.

**CHIEF COMPLAINT**

List the problems which have led you to seek medical help now and approximately when each began:

	Problem(s)	Date of Onset
1		
2		
3		
4		
5		

**GENERAL HEALTH**

Do you consider yourself basically healthy now? Yes  No  Have you been well most of your life? Yes  No

When did you last feel well? \_\_\_\_\_

How is your overall "pep" now compared with a year ago? Increased  Decreased  About the same

Has there been a net change in your weight in the past year (If so, indicate gain or loss) \_\_\_\_\_

Have you been having fever lately? Yes  No

Do you usually sleep well? Yes  No ; If yes, how many hours per night? \_\_\_\_\_

Have you been followed by a physician on a regular basis? Yes  No ; Name & Address \_\_\_\_\_

Do you regularly use your seatbelt? Yes  No

What do you do in your spare time? \_\_\_\_\_

How many hours/week do you watch TV? \_\_\_\_\_

In the past year, has there been any change in your: Marital status? \_\_\_\_\_ Work or job? \_\_\_\_\_

Residence? \_\_\_\_\_ Spare time activity? \_\_\_\_\_ Physical activity? \_\_\_\_\_ Drinking habits? \_\_\_\_\_

**PAST MEDICAL AND SURGICAL HISTORY**

List chronologically all the surgery you have had, indicating the nature of each operation and where and when it was done. (Be accurate and complete: Consult family, friends, physicians, etc.)

Operation	Hospital + City	Date

Have you ever been seriously injured? (If so, give details.) \_\_\_\_\_

List chronologically all hospitalizations not already mentioned (do not include obstetrical admissions):

Reason for Hospitalization	Hospital + City	Date

Have you ever been seriously ill otherwise? (If so, give details.) \_\_\_\_\_

Have you ever had any of the following?

Thyroid disease \_\_\_\_\_ Anemia \_\_\_\_\_ Diabetes \_\_\_\_\_ Bleeding tendency \_\_\_\_\_  
 Cancer \_\_\_\_\_ Venereal disease \_\_\_\_\_ Alcoholism \_\_\_\_\_ Drug dependence \_\_\_\_\_  
 Blood transfusion \_\_\_\_\_ AIDS \_\_\_\_\_ Any obscure or unusual disease \_\_\_\_\_

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

**RESPIRATORY**

Have you ever had any of the following? (If so, indicate when.)

Pneumonia \_\_\_\_\_

Acute bronchitis \_\_\_\_\_

Chronic bronchitis \_\_\_\_\_

Pleurisy \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Asthma \_\_\_\_\_

Emphysema \_\_\_\_\_

Pulmonary embolism \_\_\_\_\_

Other lung trouble \_\_\_\_\_

Have you ever coughed up blood? \_\_\_\_\_

Do you often or regularly:

Cough? \_\_\_\_\_

Raise sputum? \_\_\_\_\_

Do you often get colds? \_\_\_\_\_

Do your colds tend to "go to" or "settle" in your chest? \_\_\_\_\_

Do you currently smoke cigarettes? \_\_\_\_\_

How many a day? \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

Did you formerly smoke cigarettes? \_\_\_\_\_

How many a day? \_\_\_\_\_

When did you quit? \_\_\_\_\_

When was your last chest x-ray? \_\_\_\_\_

Have you ever had an abnormal chest x-ray? \_\_\_\_\_

**CIRCULATORY**

Have you ever had any of the following? (If so, indicate when.)

Heart trouble \_\_\_\_\_

Heart murmur \_\_\_\_\_

Heart attack (myocardial infarction) \_\_\_\_\_

Angina Pectoris \_\_\_\_\_

High cholesterol \_\_\_\_\_

High blood pressure \_\_\_\_\_

Rheumatic fever \_\_\_\_\_

Palpitations \_\_\_\_\_

Congestive heart failure \_\_\_\_\_

An abnormal electrocardiogram \_\_\_\_\_

An exercise stress test \_\_\_\_\_

An echocardiogram \_\_\_\_\_

Heart by-pass surgery \_\_\_\_\_

Coronary angioplasty \_\_\_\_\_

Leg cramps while walking \_\_\_\_\_

Exercise-limiting shortness of breath \_\_\_\_\_

Have you ever taken digoxin? \_\_\_\_\_

Have you ever taken nitroglycerine? \_\_\_\_\_

Have you ever taken water pills? \_\_\_\_\_

**DIETARY HABITS**  
(Indicate # servings per week)

**MEAT GROUP:**

Red Meats \_\_\_\_\_

Pork \_\_\_\_\_

Fish \_\_\_\_\_

Chicken \_\_\_\_\_

**DAIRY PRODUCTS:**

Eggs (#/wk) \_\_\_\_\_

Whole Milk \_\_\_\_\_

2% Fat Milk \_\_\_\_\_

Skim Milk \_\_\_\_\_

Cheese \_\_\_\_\_

Ice Cream \_\_\_\_\_

Yogurt (Regular or Frozen) \_\_\_\_\_

Butter \_\_\_\_\_

Margarine \_\_\_\_\_

**FRUITS:**

Fresh \_\_\_\_\_

Canned \_\_\_\_\_

**VEGETABLES:**

Fresh \_\_\_\_\_

Canned \_\_\_\_\_

**CARBOHYDRATES:**

Pasta \_\_\_\_\_

Bread \_\_\_\_\_

Cereal \_\_\_\_\_

Beans \_\_\_\_\_

Table Sugar \_\_\_\_\_

**BEVERAGES:**

Regular Coffee \_\_\_\_\_

Decaf Coffee \_\_\_\_\_

Tea \_\_\_\_\_

Decaf Tea \_\_\_\_\_

Regular Sodas \_\_\_\_\_

Decaf Sodas \_\_\_\_\_

Diet Sodas \_\_\_\_\_

Alcohol \_\_\_\_\_

Beer (# cans) \_\_\_\_\_

Wine (# glasses) \_\_\_\_\_

"Hard" (# shots) \_\_\_\_\_

**DESSERTS:**

Cakes, Pies \_\_\_\_\_

Candy \_\_\_\_\_

Do you read labels? \_\_\_\_\_

Do you add salt to your food? \_\_\_\_\_

Do you take vitamins? \_\_\_\_\_

**DIGESTIVE**

Do you often or regularly have:

Trouble swallowing \_\_\_\_\_

"Heartburn" \_\_\_\_\_

Food "repeating" \_\_\_\_\_

Nausea or vomiting \_\_\_\_\_

Abdominal pain \_\_\_\_\_

Constipation \_\_\_\_\_

Diarrhea \_\_\_\_\_

Has there been any change in your appetite in the last six months? \_\_\_\_\_

Has there been any change in the way your bowels function in the last six months (regardless of whether or not they function normally)? \_\_\_\_\_

Have you ever had any of the following? (If so, indicate when.)

Ulcer (stomach or duodenal) \_\_\_\_\_

Hiatal hernia \_\_\_\_\_

Vomiting of blood \_\_\_\_\_

Black or tarry stools \_\_\_\_\_

Yellow skin (jaundice) \_\_\_\_\_

Liver trouble \_\_\_\_\_

Gallbladder trouble or stones \_\_\_\_\_

Pancreatitis \_\_\_\_\_

Persistent diarrhea \_\_\_\_\_

Colitis or dysentery \_\_\_\_\_

Diverticulitis \_\_\_\_\_

Blood in your stool \_\_\_\_\_

Hemorrhoids \_\_\_\_\_

Hernia \_\_\_\_\_

Other digestive disease \_\_\_\_\_

Abdominal surgery \_\_\_\_\_

Have you ever had x-rays of your:

Stomach (GI series) \_\_\_\_\_

Gallbladder \_\_\_\_\_

Bowel (Barium enema) \_\_\_\_\_

**MUSCULO-SKELETAL**

Have you ever had any of the following? (If so, indicate when.)

A disk problem \_\_\_\_\_

Sciatica \_\_\_\_\_

Swelling of joint(s) (osteo arthritis) \_\_\_\_\_

Rheumatoid arthritis \_\_\_\_\_

Gout \_\_\_\_\_

Bursitis \_\_\_\_\_

Skin disorder (e.g., psoriasis, eczema) \_\_\_\_\_

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

<p><b>URINARY</b></p> <p>Have you ever had or been told you had any of the following? (If so, indicate when.)</p> <p>Nephritis or nephrosis _____</p> <p>Kidney disease _____</p> <p>Protein or albumin in urine _____</p> <p>Blood or pus in urine _____</p> <p>Urine or kidney stones _____</p> <p>Difficulty with urinary stream _____</p> <p>Bladder trouble _____</p> <p>Prostate trouble _____</p> <p>Prostate surgery _____</p> <p>Impotence _____</p> <p>How many times do you get up at night to urinate? _____</p>	<p><b>EXERCISE</b></p> <p>Do you exercise regularly? _____</p> <p>How many times/wk? _____</p> <p>How long is an average exercise session? _____</p> <p>Do you...</p> <p>Walk _____</p> <p>Jog _____</p> <p>Run _____</p> <p>Row _____</p> <p>Bike _____</p> <p>Use a bike helmet _____</p> <p>Swim _____</p> <p>Ski downhill _____</p> <p>Ski cross country _____</p> <p>Dance (type) _____</p> <p>Use an exercise bike _____</p> <p>Do aerobics _____</p> <p>Do calisthenics _____</p> <p>Lift weights _____</p> <p>Play golf _____</p> <p>Use a golf cart _____</p> <p>Play tennis _____</p> <p>Play racquetball/handball _____</p> <p>Surf _____</p> <p>If you walk, jog, bike, etc., how fast &amp; how far? _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>NEUROLOGICAL</b></p> <p>Have you ever had any of the following? (If so, indicate when.)</p> <p>Frequent or recurrent headaches _____</p> <p>Migraine headaches _____</p> <p>Loss of consciousness _____</p> <p>Convulsions or seizures _____</p> <p>A head injury _____</p> <p>Stroke _____</p> <p>Paralysis _____</p> <p>Uncontrollable movements _____</p> <p>Parkinson's Disease _____</p> <p>Difficulty with speech _____</p> <p>Double vision _____</p> <p>Numbness _____</p> <p>Hallucinations _____</p> <p>Nervous breakdown _____</p> <p>Severe depression or nervousness _____</p> <p>Crying spells _____</p> <p>Other Psychiatric condition _____</p>
<p><b>OBSTETRIC &amp; GYNECOLOGICAL</b></p> <p>Have you ever had tumor(s), cyst(s), or other breast disease? _____</p> <p>Have you ever had a mammogram? _____</p> <p>How many times have you been pregnant (including miscarriages)? _____</p> <p>How many live births? _____</p> <p>Do you ever bleed ("spot") between periods or after intercourse? _____</p> <p>Do your periods ever last longer than you expect? _____</p> <p>Do you get yearly pap smears? _____</p> <p>Have you ever had toxemia? _____</p> <p>Have you had a hysterectomy? _____</p> <p>Have you had any other surgery of your female organs? _____</p> <p>Are you now taking hormones or birth control pills? _____</p> <p>Do you smoke cigarettes? _____</p> <p><i>If you are still menstruating...</i></p> <p>What is the date of:</p> <p>You last period? _____</p> <p>The one before? _____</p> <p>How many days do your periods usually last? _____</p> <p>Are your periods regular? _____</p> <p>What is your cycle length? _____</p> <p><i>If you've had your change of life...</i></p> <p>When was your last period? _____</p> <p>Have you bled since? _____</p>	<p>Do you get any unusual symptoms when you exercise (i.e., lightheadedness, chest pain or pressure, leg pain, severe shortness of breath)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(Describe)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>EYES, EARS, NOSE, THROAT</b></p> <p>Have you ever had:</p> <p>Eye surgery _____</p> <p>Glaucoma _____</p> <p>Other major eye disease (specify) _____</p> <p>Deafness _____</p> <p>Abnormal noises in the ear _____</p> <p>Nose or throat surgery _____</p>
		<p><b>ALLERGIES</b></p> <p>Have you ever had:</p> <p>Hives _____</p> <p>Asthma _____</p> <p>Hay fever _____</p> <p>Other allergies _____</p> <p>Have you ever had a bad reaction to penicillin or any other drug (e.g., rash, itching, swelling, etc.)? (If so, give name of drug and kind of reaction) _____</p> <p>_____</p> <p>_____</p>

**CURRENT MEDICATIONS**

List all the medications you are now taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list **MUST** be detailed, accurate, and complete; therefore, consult with your family, druggist, physician. (Do not neglect aspirin and other pain medicines; hormones; contraceptive, water, diet, nerve, or sleeping pills.)

Name of Medicine	Strength each dose	How often taken	When began taking

**PERSONAL HISTORY**

In what state or foreign country were you born? \_\_\_\_\_

Are you married? \_\_\_\_\_ How long? \_\_\_\_\_

Have you been married in the past? \_\_\_\_\_

How many times? \_\_\_\_\_

Do you have a pet? \_\_\_\_\_

What is your current occupation? \_\_\_\_\_

Do you enjoy your work(retirement)? \_\_\_\_\_

Have you ever worked in the field of medicine, in any capacity (including volunteer, aide, clerk, technician)? \_\_\_\_\_

How far did you go in school? \_\_\_\_\_

Name of college or graduate school \_\_\_\_\_

List the areas you have lived in chronologically, giving dates:

Area	From	To

List your past occupations chronologically, giving dates:

Occupation	From	To

**FAMILY HEALTH**

Please give the following information about the health of your immediate family:

Relation	Age/Sex	Age at death	State of health or cause of death
Mother			
Father			
Brothers and Sisters			
Spouse			
Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)

- |                                      |                            |  |
|--------------------------------------|----------------------------|--|
| Diabetes _____                       | Cancer _____               | High blood pressure (Hypertension) _____       |
| Rheumatoid arthritis _____           | Blood disease _____        | Any obscure or unusual disease _____           |
| Thyroid disease _____                | Epilepsy _____             | Psychiatric disease or nervous breakdown _____ |
| Heart attack or bypass surgery _____ | Alcoholism _____           | A disease which "runs in the family"? _____    |
| _____                                | Cholesterol problems _____ | Other _____                                    |

# ARES™ Screener Questionnaire ©

**PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX**

First Name		Middle Initial		Last Name	
Neck Size	Inches	Age		Years	Gender Male <input type="radio"/> Female <input type="radio"/>
Height	Feet	Inches		Weight	Pounds
Date of Birth	Month	Day	Year	ID Number	Optional

**COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION - ANSWER ALL QUESTIONS**

**Have you been diagnosed or treated for any of the following conditions?**

High Blood Pressure	Yes <input type="radio"/>	No <input type="radio"/>	Sleep Apnea	Yes <input type="radio"/>	No <input type="radio"/>
Heart Disease	Yes <input type="radio"/>	No <input type="radio"/>	Currently Pregnant	Yes <input type="radio"/>	No <input type="radio"/>
Diabetes	Yes <input type="radio"/>	No <input type="radio"/>	Nasal or Mask Oxygen Use	Yes <input type="radio"/>	No <input type="radio"/>
Stroke	Yes <input type="radio"/>	No <input type="radio"/>	Depression	Yes <input type="radio"/>	No <input type="radio"/>

**Epworth Sleepiness Scale:** How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

**0 = would never doze    1 = slight chance of dozing    2 = moderate chance of dozing    3 = high chance of dozing**

	0	1	2	3
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**On average in the past month, how often have you snored or been told that you snored?**

Never <input type="radio"/>	Rarely <input type="radio"/> 0-1 times/week	Sometimes <input type="radio"/> 1-2 times/week	Frequently <input type="radio"/> 3-4 times/week	Almost always <input type="radio"/> 5-7 times/week
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**Do you wake up choking or gasping?**

Never <input type="radio"/>	Rarely <input type="radio"/> 0-1 times/week	Sometimes <input type="radio"/> 1-2 times/week	Frequently <input type="radio"/> 3-4 times/week	Almost always <input type="radio"/> 5-7 times/week
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**Have you been told that you stop breathing in your sleep or wake up choking or gasping?**

Never <input type="radio"/>	Rarely <input type="radio"/> 0-1 times/week	Sometimes <input type="radio"/> 1-2 times/week	Frequently <input type="radio"/> 3-4 times/week	Almost always <input type="radio"/> 5-7 times/week
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Signature	Month	Day	Year	Area Code	Phone Number
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