SDCVA NEW PATIENT HISTORY FORM

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Name: ____ Date: ________________________

Date of Birth: __________________ Age: ________ Occupation: _________________________

Marital Status: ______________ Single: ____________Married _______________Widower/Widow ________

Where were you born __________________________ Level of Education ___________________________

What is the reason for your visit today? ____

PAST MEDICAL HISTORY:

Have you ever had or been treated for the following diseases:? Please circle yes or no.

Rheumatic Fever yes/no If yes, at what age? ____

Heart Murmur yes/no What year was this first noted? ___________________________________

Heart Attack yes/no Dates ____

High Cholesterol yes/no How many years ________________ Level ____________

High Triglycerides yes/no How many years ________________ Level ____________

High Blood Pressure yes/no How many years ____

Diabetes yes/no How many years _______________________________________

Controlled by: Diet Pills Insulin

Have you ever had the following tests performed, please answer yes or no

Heart Catheterization yes/no Date _______________ Place ____________________________

Angioplasty yes/no Date _______________ Place ____________________________

Heart Surgeries yes/no Date _______________ Place ____________________________

Treadmill yes/no Date _______________ Place ____________________________

Echocardiogram yes/no Date _______________ Place ____________________________

Nuclear stress test yes/no Date _______________ Place ____________________________

Other Cardiac Studies (M U GA, etc.) yes/no Date _______________ Place ____________________________

PREVIOUS SURGERIES: Patient Name: ______________________________

Type of Surgery	Place	Date
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________

MAJOR ILLNESS OR INJURIES:

Reason for Admission	Place	Date
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________

PERSONAL HABITS:

Do you or have you ever smoked or chewed tobacco? _____ Yes _____ No

If yes:

Cigarettes	_____ Yes	____ No	_____pack/day for	_____ years	Date Stopped ___________________
Cigars	_____ Yes	____ No	_____pack/day for	_____ years	Date stopped ____________________
Pipe	_____ Yes	____ No	_____pack/day for	_____ years	Date stopped ____________________
Chew	_____ Yes	____ No	_____pack/day for	_____ years	Date stopped ____________________

Do you or have you ever consumed alcohol? _____ Yes ______ No

If yes:	Casual	Daily	Excessive	Amount ______________________
Caffeine:	Casual	Daily	Excessive	Amount ______________________

Any type of special diet required: ____

Exercise: ____

Do you enjoy your work or retirement? ____

Do you have difficulty falling asleep? ____

MEDICATIONS:

List below all medications, vitamins, laxatives. etc., that you have taken regularly during the past month. If the name of the medications is not known, please find the name from your pharmacist. Bring all medications with you.

Name & Dosage	How often taken	Purpose Taken
______________________	_________________________	________________________
______________________	_________________________	________________________
______________________	_________________________	________________________

MEDICATIONS, CONTINUED Patient Name: ___________________________

Name & Dosage	How often taken	Purpose Taken
_______________________	__________________________	_________________________
_______________________	__________________________	_________________________
_______________________	__________________________	_________________________
_______________________	__________________________	_________________________
_______________________	__________________________	_________________________
_______________________	__________________________	_________________________

ALLERGIES:

Drug or other allergy	Reactions
___________________________	____
___________________________	____
___________________________	____

Are you allergic to contrast dye or iodine? If so list reaction ____

FAMILY HISTORY

Mother:

If living: Her age ______years

History of heart disease: ____yes ____no

If yes: What age diagnosed: ___________

Health:

If deceased: Age at death _____ years

Cause: ____________________________

Father:

If living: His age ______years

History of heart disease: ____yes ____no

If yes: What age diagnosed: ___________

Health:

If deceased: Age at death _____ years

Cause: ____________________________

Living Brother or Sister:

Age: ______ Sex: ______ Health:____
Heart Disease Yes ______ No ____ What age diagnosed?_________________________________

Age: ______ Sex: ______ Health: ____
Heart Disease Yes ______ No ____ What age diagnosed?__________________________________

Age: ______ Sex: ______ Health: ____
Heart Disease Yes ______ No ____ What age diagnosed?__________ _______________________

Age: ______ Sex: ______ Health: ____
Heart Disease Yes ______ No ____ What age diagnosed?__________________________________

Age: ______ Sex: ______ Health: ____
Heart Disease Yes ______ No ____ What age diagnosed?_______________________________________

Children: Yes ______ No ____ How many?____

Patient Name:______________________________

ARE YOU EXPERIENCING THE FOLLOWING PROBLEMS?
Circle Yes and No to each question.

Yes No Do you frequently have severe headaches? (If yes answer the following)
Yes No Do they cause visual trouble?
Yes No Do they feel like a tight band?
Yes No Does aspirin relieve them?
Yes No Do they occur on one side of your head?
Yes No Do they awaken you at night from sleep?
Yes No migranes?

Have you ever experienced?

Yes	No	tremors?	Yes	No	conjuctivitis?
Yes	No	spells of dizziness or motion sickness?	Yes	No	double vision/vision change?
Yes	No	fainting spell?	Yes	No	ringing in the ears?
Yes	No	spells of weakness of an arm or leg?	Yes	No	severe change in hearing?
Yes	No	seizures/convulsions?	Yes	No	nosebleeds?
Yes	No	pain or drainage in the ears?	Yes	No	abnormality of taste or smell?
Yes	No	gland swelling or lumps in the neck?	Yes	No	serious allergy symptoms
Yes	No	do you have a chronic cough or sore throat?	Yes	No	severe persistent dry mouth?
Yes	No	a stroke	Yes	No	Tia/mini-stroke?

Do you frequently have…?

Yes	No	bleeding gums or serious dental problems?	Yes	No	trouble swallowing?
Yes	No	sore tongue or white patches?	Yes	No	hoarseness/significant voice change?

Patient Name:______________________________

Have you ever had shortness of breath?

Yes	No	doing your usual work?	Yes	No	which causes you to cough?
Yes	No	climbing a flight of stairs?	Yes	No	accompanied by wheezing?
Yes	No	which awakens you at night?	Yes	No	Do you sleep with more than one pillow?

Have you ever had…?

Yes	No	pleurisy?	Yes	No	do you cough up sputum?
Yes	No	do you have a chronic cough ?	Yes	No	do you cough up blood?
Yes	No	blood clot in your lungs?	Yes	No	asthma?
Yes	No	tuberculosis?	Yes	No	pneumonia?
Yes	No	COPD/emphysema?	Yes	No	bronchitis?

Have you ever had chest pain or tightness on the chest…

Yes	No	when exerting yourself?	Yes	No	when upset or excited?
Yes	No	when walking up hill?	Yes	No	that disappears if you rest?
Yes	No	after a heavy meal?	Yes	No	which only occurs at rest?
Yes	No	which radiates down your arm/into neck?	Yes	No	do you have palpitations?
Yes	No	when walking fast?	Yes	No	do you have an irregular heart beat?

Have you recently had pain in the stomach which…

Yes	No	occurs after eating fried foods/gassy foods?	Yes	No	occurs 1-2 hours after a meal?
Yes	No	occurs while eating or immediately after?	Yes	No	awakens you at night?
Yes	No	is relieved by a bowel movement?	Yes	No	causes loss of appetite?
Yes	No	is relieved by antacid medications?	Yes	No	is relieved with milk or eating?

Patient Name:________________________________

Have you had…

Yes	No	bleeding ulcer?	Yes	No	loss of bladder control?
Yes	No	nausea and vomiting?	Yes	No	blood in your stools?
Yes	No	black stools?	Yes	No	vomited blood?
Yes	No	diarrhea/loose stools?	Yes	No	constipation?
Yes	No	colonoscopy?	Yes	No	endoscopy?
Yes	No	trouble urinating?	Yes	No	prostate problems?
Yes	No	kidney stones?	Yes	No	kidney problems?
Yes	No	hepatitis?	Yes	No	jaundice?

Have you had…

Yes	No	weight loss?	Yes	No	weight gain?
Yes	No	fever chills or night sweats?			

Have you had…

Yes	No	pain in calves when walking?	Yes	No	swelling in the ankles/feet?
Yes	No	cramps in the legs at night?	Yes	No	gout?
Yes	No	blood clots in your legs?	Yes	No	phlebitis?
Yes	No	varicose veins?	Yes	No	arthritis?

Have you had…

Yes	No	severe dry or oily skin?	Yes	No	skin lumps/rash/itching?
Yes	No	hair/nail change?	Yes	No	skin cancer?
Yes	No	shingles?			

Have you had…

Yes	No	thyroid disease?	Yes	No	goiter?

Have you had…

Yes	No	Depression?	Yes	No	Anxiety?
Yes	No	Suicide attempt?			

Have you had…

Yes	No	bleeding tendency?	Yes	No	Leukemia?
Yes	No	cancer?	Yes	No	blood transfusion?

Other information:____

____

Patient Signature____Date________________________

Physician Signature____Date________________________