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SOUTH TAMPA CARDIOLOGY

PATIENT HISTORY FORM

Appointment Date_____ **Name** _____

Appointment Time_____ **Referring Physician** _____

Date of Birth _____ **Social Security #** _____ / _____ / _____

PHYSICIANS

List all doctors providing care

Doctor's Name	Type of Doctor *Primary Care, Urologist, etc*	Reason for seeing this doctor
	Primary Care Doctor	

ALLERGIES

Do you have allergies to drugs, food, latex, dye? YES NO

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc

CURRENT MEDICATIONS

List all vitamins, prescription medications, and over-the-counter medications.

♥ **BRING all medications in their original containers to your appointment!**

Medication Name	Dosage	How often do you take?	Prescribing Physician

REVIEW OF SYSTEMS **Circle if you are experiencing symptoms or check " *No Symptoms* "**

General
☐ *No Symptoms*
Recent Fever
Chills
Night Sweats
Recent weight loss/gain
Loss of energy

Integumentary (Skin)
☐ *No Symptoms*
Rashes
Changes in mole
Changes in hair or nails
Discharge from nipples
Breast lumps
Breast biopsy

Eyes
☐ *No Symptoms*
Blind spots
Double vision
Recent change in vision

Ears, Nose, and Throat
☐ *No Symptoms*
Recent Hearing loss
Ringing in ears
Sore throat
Difficulty swallowing
Nasal Congestion
Nose bleeds

Respiratory
☐ *No Symptoms*
Recent Cough
Wheezing
Pain when breathing
Excessive sputum

Cardiovascular
☐ *No Symptoms*
Chest pain
Shortness of Breath
Leg Swelling
Heart murmur
Palpitations
Phlebitis

Abdominal
☐ *No Symptoms*
Nausea
Vomiting
Diarrhea
Constipation
Abdominal pain/cramping
Blood in stools

Genitourinary
☐ *No Symptoms*
Burning on urination
Bloody urine
Difficulty urinating
Urination at night:
# of times_____
Difficulty with erections

Musculoskeletal
☐ *No Symptoms*
Unusual muscle aches
Arthritis
Back problems

Neurological
☐ *No Symptoms*
Headaches
Dizziness
Stroke
Weakness
Numbness

Psychiatric
☐ *No Symptoms*
Depression
Anxiety
Substance Abuse
Change in cognitive function

Endocrine
☐ *No Symptoms*
Unexplained changes in weight
Goiter
Excessive thirst
Increased urination

Hematological
☐ *No Symptoms*
Excessive Bleeding
Easy bruising

PAST MEDICAL HISTORY **Circle past history**

Past Illnesses
Asthma
Bronchitis/Emphysema
Cancer
Diabetes
Kidney stones/kidney failure
Liver/Gallbladder
Peptic Ulcer - GERD
Prostate
Rheumatic Fever
Seizures
Sleep Apnea
Stroke/CVA
Thyroid Disease
Other _____
_____

Infectious Disease History
_____
_____

Trauma History
_____
_____

Past Cardiac Illnesses
Angina/Chest Pain
Atrial Fibrillation
Congestive heart failure (CHF)
Coronary artery disease
Heart Attack (MI)
High Blood Pressure
High Cholesterol
Irregular heartbeat (arrhythmias)
Peripheral Vascular Disease
Valvular heart disease

Other _____
_____
_____
_____

Past Surgeries/Procedures
Appendectomy
Back
Breast
Cataract
Gallbladder
Hernia – Hiatal/Inguinal
Hip
Hysterectomy
Intestinal
Knee
Prostate
Tonsils/Adenoids
Other _____
_____

Past Cardiac Surgery/Procedures
Cardiac Cath
Cardioversion
Coronary angioplasty / Stent
Coronary artery bypass
EP Study
ICD
Pacemaker implant
RF ablation

SOCIAL HISTORY AND LIFESTYLE

Alcohol Use

Yes No Do you consume alcohol?
Average number per day
___ beer ___wine ___ liquor

Smoking/Tobacco Use

Yes No Do you smoke or use tobacco?
Yes No Have you smoked in the past?
Number of years? ____ Packs per day _____

Diet

Yes No Are you on a special diet?
What type of diet? _____
Yes No Do you drink caffeinated beverages?
(coffee, tea, cola. etc)
How many daily? _____

Exercise

Yes No Do you exercise on a regular basis?
Minimum of 30 minutes / 3 times a week

Substance Abuse

Yes No Do you have a history of drug dependency?
If yes, specify: _____

Lifestyle ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Occupation _____
☐ Retired
☐ Unemployed

Residence
☐ Lives alone
☐ Lives with children
☐ Lives with parents
☐ Lives with spouse
☐ Lives with spouse/children
☐ Lives with male partner
☐ Lives with female partner
☐ Nursing home resident
☐ Assisted living resident

What do you like to do (hobbies)?

_____

_____

_____

FAMILY MEDICAL HISTORY

Family Cardiac History

Father
☐ Alive ☐ Deceased at age _____
☐ Heart attack before age 60
☐ Stroke
☐ Sudden cardiac death

Mother
☐ Alive ☐ Deceased at age _____
☐ Heart attack before age 60
☐ Stroke
☐ Sudden cardiac death

Sibling(s)

_____**Number of Brother(s)**
#_____ Alive
_____ Deceased
at age(s) _____
☐ Heart attack before age 60
☐ Stroke
☐ Sudden cardiac death

_____**Number of Sister(s)**
#_____ Alive
_____ Deceased
at age(s) _____
☐ Heart attack before age 60
☐ Stroke
☐ Sudden cardiac death

Personal Cardiac Risk Factors

☐ History of tobacco use
☐ Family history heart disease *(immediate family)*
☐ History high cholesterol
☐ High blood pressure
☐ History of diabetes
☐ Prior history of heart disease
☐ History of obesity
☐ Sedentary lifestyle
☐ Age *(Male over 45 - Female over 55)*
☐ Menopausal female