CARDIAC CARE CONSULTANTS
CARDIOLOGY

Triple i / CliniForms
HISTORY & PHYSICAL

Name _____ SS# _____ Date _____

Address _____ Occupation _____

Phone (home) _____ (work) _____ Date of birth _____ Age ____

Chief complaint _____

DRUG ALLERGIES

_____

_____

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Other_____	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

MEN ONLY: *It's common for men to occasionally experience erection difficulties. Is this something that happens to you?* ❑ *Yes* ❑ *No*
Do you occasionally experience erection difficulties? ❑ *Yes* ❑ *No*

MEDICAL HISTORY

❑ Scarlet fever _____ ❑ Asthma _____ ❑ Shortness of breath _____ ❑ Endocrine disease _____

❑ Epilepsy _____ ❑ Anxiety _____ ❑ Orthopnea _____ ❑ Stroke / TIAs _____

❑ Menstrual Dysfunction _____ ❑ MI _____ ❑ Anemia _____ ❑ Sexual Dysfunction _____

❑ Dizziness / Fainting _____ ❑ Renal disease _____ ❑ GI disorder _____ ❑ Chest pain / Angina _____

❑ Rheumatic fever _____ ❑ COPD _____ ❑ Heart palpitations _____ ❑ Hypertension _____

❑ Allergies / Hayfever _____ ❑ Fatigue _____ ❑ Hyperlipidemia _____ ❑ Arrhythmia _____

❑ Arthritis _____ ❑ Congenital heart disease _____ ❑ Gout _____ ❑ Congestive heart failure _____

❑ Claudication _____ ❑ Liver disease _____ ❑ GU disorder _____ ❑ Diabetes _____

❑ Venereal disease _____ ❑ Ulcer _____ ❑ Heart murmur _____ ❑ Other _____

HABITS

❑ Smoke: Packs daily _____
How long _____
Interested in stopping? _____

❑ Exercise routine: _____
_____

❑ Contact with blood/bodily fluid at work: ____

❑ Coffee: Cups daily _____
Other caffeine _____

❑ Alcohol: Type _____
Amount _____

❑ Diet: Salt intake _____
Fat intake _____

❑ Sleep: Difficulty falling asleep ____
Continuity disturbances ____
Snoring _____
Early morning awakening ____
Daytime drowsiness _____
Other _____

MISCELLANEOUS NOTES

_____

_____

_____

_____

_____

Name _____

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Name _____ SS# _____ Date _____

REVIEW OF SYSTEMS

❑ Neurologic _____ ❑ GI _____ ❑ Cardiovascular _____

❑ GU _____ ❑ Cerebrovascular _____ ❑ Musculoskeletal _____

❑ Peripheral vascular _____ ❑ Dermatologic _____ ❑ Hematologic _____

PHYSICAL EXAM

Temperature _____ Pulse _____ BP _____

Height _____ Weight _____ Respiration _____

General Appearance _____

	N	AB	Notes
Skin			
HEENT			
Neck			
Thyroid			
Lymph nodes			
Veins/carotid			
Chest			
Lungs			
Heart			
Abdomen			
Genital			
Rectal			
Extremities			
Joints			
Clubbing/cyanosis			
Peripheral pulses			
Edema			
Neurologic			

TESTS ORDERED

❑ EKG _____ ❑ Stress ECG _____ ❑ Holter _____ ❑ Echo _____

❑ Angiogram _____ ❑ Chest X-ray _____ ❑ Cholesterol _____ ❑ Pulmonary Function _____

❑ SMA _____ ❑ CBC _____ ❑ Urinalysis _____ ❑ Thyroid _____

IMPRESSIONS

_____

_____

MISCELLANEOUS NOTES

_____

_____

_____

_____

_____

Name _____