Date:_____ Technician:

Name:_____ Age:_____ Ht._____

Marital Status:_____ Number of children_____ Wt._____

PRIMARY CARE DOCTOR(s)_____ BP_____

WHAT PROBLEM BROUGHT YOU TO THIS OFFICE?_____

WHAT PHARMACY DO YOU USE_____

General Information

Have you ever had any of the following problems?

Chest Pain	_____	Rheumatic Fever	_____	Heart Attack	_____
Shortness of Breath	_____	Heart Murmur	_____	Abnormal Heartbeat	_____
Heart Failure	_____	Stroke	_____	Blood Clots	_____
Enlarged Heart	_____	Abnormal EKG	_____	Leg Pain	_____

RISK FACTORS FOR HEART DISEASE

Cigarettes

1 Do you smoke cigarettes?____Use other tobacco?_____
How many did/do you smoke per day? _____For how many years?_____

Blood Pressure

2. Do you have high blood Pressure?_____If yes, for how many years?_____
How many years have you been treated for high blood pressure?_____

Lipids

3. Have you ever been told you have an abnormal:
Cholesterol?____Triglycerides?____HDL?____
Do you know the numbers?_____

4. Are you on a low fat diet? Yes____ No_____

Diabetes

5. Do you have diabetes?_____ How long?_____
What treatment? Diet____ Insulin_____ Drugs_____

Family History

6. Do you have a family history of heart attacks or sudden death? _____
Mother____ Father_____ Brothers_____ Sisters_____

Exercise

7. How much exercise do you get?
A. No regular exercise program _____ B. Irregular exercise _____
C. Regular exercise (list what you do)_____

Menopause

8. Have you gone through menopause: _____
Are you currently receiving hormone replacement therapy?_____

Weight

9. What is your highest and lowest adult weight? _____/_____
Present weight? _____

Personality

10. What is your personality type?
Tense_____ Relaxed _____ Average_____

Stress

11. Have there been any stresses in your life that may be contributing to your problems? _____

LIST YOUR MEDICINES

NAME OF MEDICINE	MG	TIMES A DAY YOU TAKE IT

PERSONAL HISTORY

ALLERGIES/LIST MEDICATIONS: _____

_____

Do you use alcohol at all?_____
How many drinks a day (average)?_____
How many beers a day?_____ Did you ever drink more?_____

How much coffee do you drink a day? Decaffeinated_____
Less than 2 cups_____ 2-5 cups_____ More than 5 cups_____

Are you employed outside the home?_____ Retired?_____
Describe your position:

If you are retired, how do you spend your time?

PREVIOUS HISTORY

TYPE OF OPERATION:_____ **DATE:**_____

1._____

2._____

3._____

PAST MEDICAL HISTORY

Have you been in the hospital for any serious illness?_____

PROBLEM:

1._____

2._____

3._____

FAMILY HISTORY (do not list names)

FAMILY MEMBER	AGE	ALIVE (YES/NO)	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				

Did any family member, mother, father, brother, sister- have any of the following:

	WHO HAD IT	How old were they when
Stroke		
Heart Attack		
Hypertension		
Diabetes		
Abnormal blood fats		

REVIEW OF YOUR GENERAL MEDICAL HISTORY

CHECK ANY OF THE PROBLEMS THAT YOU HAVE OR HAD IN THE PAST:

		NOW	PAST
GENERAL:	Weight loss of more than 5 pounds in past six mo.	____	____
	Undue tiredness	____	____
	Poor appetite	____	____
EYES AND EARS:	Double vision	____	____
	Loss of vision (even brief)	____	____
	Difficulty hearing	____	____
MOUTH:	Gum or teeth problems	____	____
PULMONARY:	Cough	____	____
	Coughed up any blood	____	____
	Recurrent chest infections	____	____
GASTRO-INTESTINAL:	History of ulcer	____	____
	Hiatal hernia	____	____
	Burning in pit of stomach between meals or at night	____	____
	Liver disease	____	____
	Constipation or diarrhea	____	____
	Rectal bleeding or black tarry stools	____	____
GENITOURINARY:	Kidney or bladder infections	____	____
	Frequent urination	____	____
	Get up at night to urinate	____	____
	Difficulty starting or stopping your stream	____	____
EXTREMITIES:	Varicose veins	____	____
	Phlebitis	____	____
	Leg pain	____	____
NEUROLOGICAL:	Stroke	____	____
	Frequent headaches	____	____
	Paralysis of any part of your body	____	____
	Not being able to talk distinctly	____	____
	Seizure	____	____
ENDOCRINE:	Thyroid trouble	____	____
	Women: are your menses (periods) normal	____	____
	Do you feel hot more often than other people	____	____
HEMATOLOGY:	Have you ever received a transfusion	____	____
	Do you bleed a lot with cuts	____	____
	Have you ever been anemic	____	____
	Have you ever been told you have a bleeding problem	____	____
PSYCHIATRIC:	Have you ever seen a psychiatrist	____	____
OB-BYN:	Birth control pills or hormone supplement	____	____