

Job I.D.# _____
or
Dictated to _____
PA/NP _____



PATIENT HISTORY

PHYSICIAN _____ DATE _____ REF. MD _____ CLINIC SITE _____

PLEASE COMPLETE BLACK PRINTED AREAS

REASON FOR YOUR VISIT _____

PATIENT NAME _____ D.O.B. _____

QSI # _____ Sex _____

WHEN DID THIS BEGIN _____

FOR NURSE/ASSISTANT USE ONLY

CARDIAC HISTORY (Circle appropriate response)

- | | | |
|--|-----|----|
| 1. Heart attack | YES | NO |
| If yes, when? _____ | | |
| 2. Coronary artery dye test | YES | NO |
| If yes, when? _____ | | |
| 3. Heart surgery or balloon/stent procedure | YES | NO |
| Date _____ Type _____ | | |
| 4. Echocardiogram (ultrasound of heart) | YES | NO |
| *5. Chest pain, tightness, heaviness | YES | NO |
| *6. Are you short of breath with activity? | YES | NO |
| *7. Do you wake up gasping for air? | YES | NO |
| *8. Do you require more than one pillow to sleep on? | YES | NO |
| *9. Legs and ankles swell? | YES | NO |
| *10. Heart skips beats or pounds/beats too fast? | YES | NO |
| *11. Fainting? | YES | NO |
| *12. Dizziness/Lightheadedness? | YES | NO |
| 13. Pericarditis? | YES | NO |
| 14. Rheumatic fever? | YES | NO |
| 15. Heart murmur? | YES | NO |

VITALS: HT. _____ WT. _____ WAIST _____

B.P. RT. _____ / _____ LT. _____ / _____

PULSE _____ R. _____ T. _____

ABI's: R) _____ L) _____ by _____

MEDICATION ALLERGIES: _____

MEDICATIONS/02/CPAP

VASCULAR HISTORY

- | | | |
|--|-----|----|
| 1. Pain in calves/thighs/buttocks when walking? | YES | NO |
| How far do you walk prior to pain? _____ | | |
| 2. Any sores on legs/feet? | YES | NO |
| 3. Previous surgery on arteries (legs, abdomen, neck) | YES | NO |
| 4. Aneurysm (ballooning of artery) | YES | NO |
| 5. Previous carotid doppler (ultrasound of arteries of neck) | YES | NO |
| 6. Previous arterial doppler (leg circulation test) | YES | NO |
| 7. Blood clots in legs/lungs | YES | NO |
| 8. Varicose veins | YES | NO |

PHYSICIAN'S USE ONLY

CARDIOVASCULAR RISK FACTOR SURVEY

- | | | |
|---|-----|--------------------------|
| *1. Do you smoke/chew tobacco or have you in the past? | YES | NO |
| a. Packs/day _____ b. Years smoked _____ c. Year quit _____ | | |
| *2. Do you have a history of high blood pressure? | YES | NO |
| How long? _____ | | |
| *3. Do you have a history of high blood cholesterol? | YES | NO |
| *4. Are you diabetic? If yes, how long? _____ | YES | NO |
| *5. Is there a family history of . . . | | Please list relationship |
| a. Heart Disease | YES | NO _____ |
| b. Diabetes | YES | NO _____ |
| c. Cancer | YES | NO _____ |
| d. Stroke | YES | NO _____ |

Physician: _____ Room # _____

* Complete Questions on Each Visit

OVER

PAST MEDICAL HISTORY:**Previous Surgeries & Chronic Conditions**

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HABITS/SOCIAL HISTORY: Please Circle

1. Do you follow a special diet? YES NO
2. Do you use caffeine? YES NO
 - a. Amount/day? _____
3. Do you use alcohol? YES NO
 - a. Amount/day? _____
4. Do you have a history of drug use/abuse? YES NO
5. Occupation _____ Marital Status _____

REVIEW OF SYSTEMS: Please Circle**A. GENERAL**

- a. Do you tire easily? YES NO

When did you first notice? _____
- b. Have you had a recent fever, chills or sweats? YES NO
- c. Skin rashes? YES NO
- d. Have you had a recent weight loss/gain? YES NO

Amount _____

B. EYES

- Have you ever had
- a. Blurry vision YES NO
 - b. Glaucoma YES NO
 - c. Partial or total loss of vision/lenses YES NO
 - d. Cataracts YES NO

C. THROAT, MOUTH, AND EARS

- Do you have any problems with
- a. nose YES NO
 - b. sinus YES NO
 - d. mouth/teeth YES NO
 - e. throat YES NO
 - g. hearing/ears YES NO
- Comment: _____

D. RESPIRATORY

- Have you had
- a. Asthma or wheezing? YES NO
 - b. Emphysema or bronchitis? YES NO
 - c. Chronic cough? YES NO
 - d. Bloody sputum? YES NO
 - e. Do you snore loudly? YES NO
 - f. Do you wake up more than once a night? YES NO
 - g. Are you tired first thing in the AM? YES NO

E. GASTROINTESTINAL

- Do you have
- a. Heartburn YES NO
 - b. Sour regurgitation/acid reflux YES NO
 - c. Difficulty swallowing YES NO
 - d. Hiatal hernia YES NO
 - e. Stomach ulcer YES NO
 - f. Rectal bleeding/black or bloody stools YES NO
 - g. Gall bladder problems YES NO
 - h. Recent change in bowel habits YES NO
 - i. Liver disease/Hepatitis YES NO

F. GENITO-URINARY TRACT

- Do you have
- a. Blood in urine YES NO
 - b. Problems with urination YES NO
 - c. Urinary Infections YES NO
 - d. Kidney/Bladder Stones YES NO
 - e. Kidney failure/Dialysis YES NO
 - f. Do you have nighttime urination? YES NO

How often? _____
 - g. Impotence YES NO
 - h. Menopause YES NO
 - i. Hysterectomy YES NO

G. MUSCULOSKELETAL

- Have you had
- a. Arthritis YES NO
 - b. Gout YES NO
 - c. Muscle or Joint Pains YES NO

H. ENDOCRINE

- a. Have you had thyroid problems? YES NO
- b. Diabetes? YES NO

I. HEMATOLOGY/LYMPHATIC

- Have you had
- a. Anemia YES NO
 - b. Bruise/bleed easily YES NO
 - c. Cancer YES NO

Where? _____

J. NEUROLOGIC

- Have you had
- a. Chronic Headaches YES NO
 - b. Dizziness/lightheadedness YES NO
 - c. Fainting YES NO
 - d. Stroke YES NO
 - e. Seizure disorder YES NO
 - f. Numbness/tingling YES NO

K. PSYCHIATRIC

- a. Do you have a history of mental illness? YES NO
- b. Do you have feelings of depression? YES NO
- c. Do you have an anxiety problem? YES NO

PHYSICAL EXAMINATION

General: development distress mood/affect skin
VITALS:

ENT: xanthelasma oral mucosa

NECK: carotids JVD thyroid

CHEST: respirations lungs AP diameter

HEART: rhythm gallop/murmur palpation

ABD: soft tenderness organomegaly bruits bowel sounds

RECTAL/PELVIC:

EXTREM: clubbing/cyanosis pulses

edema varicose veins bruits

NEURO: IOC, grasp, reflexes, focal deficits