Job I.D.#_____
or
Dictated to_____

PA/NP _____

Nebraska Heart Institute

PATIENT HISTORY

PHYSICIAN _____ DATE _____ REF. MD _____ CLINIC SITE _____

PLEASE COMPLETE BLACK PRINTED AREAS

REASON FOR YOUR VISIT_____

_____

_____

WHEN DID THIS BEGIN_____

CARDIAC HISTORY *(Circle appropriate response)*

1. Heart attack If yes, when? _____	YES	NO
2. Coronary artery dye test If yes, when? _____	YES	NO
3. Heart surgery or balloon/stent procedure Date _____ Type _____	YES	NO
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

VASCULAR HISTORY

1. Pain in calves/thighs/buttocks when walking? How far do you walk prior to pain? _____	YES	NO
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

CARDIOVASCULAR RISK FACTOR SURVEY

*1. Do you smoke/chew tobacco or have you in the past? a. Packs/day ____ b. Years smoked ____ c. Year quit ____	YES	NO
*2. Do you have a history of high blood pressure? How long? _____	YES	NO
*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	_____

*** Complete Questions on Each Visit**

*****OVER*****

PATIENT NAME _____ D.O.B._____

QSI # _____ Sex _____

FOR NURSE/ASSISTANT USE ONLY_____

VITALS: HT. _____ WT. _____ WAIST _____

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

PULSE _____ R. _____ T. _____

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

MEDICATION ALLERGIES:_____

MEDICATIONS/02/CPAP

PHYSICIAN'S USE ONLY

Physician: _____ **Room #** _____

FORM 94
Rev. 11/05

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 va ties bruits
NEURO: IOC, grasp, , focal deficits