

Saint Thomas Heart Confidential Patient History: Please answer all questions. List your name and the date on each page. 1

Date _____

Name _____ Age _____ Birthdate _____ Sex: M F

Height _____ Weight _____ Race _____

Doctor who sent you _____ & phone # or city (if not local) _____

Reason for today's visit: (list problems, concerns & when they began)

Your HEART history & risk factors— **NO** **YES** **If yes, EXPLAIN** with the year & name of doctor / hospital

Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Angioplasty / stent / balloon / 'roto-rooter'	<input type="checkbox"/>	<input type="checkbox"/>	
Coronary (heart) bypass surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other heart surgery (valve replaced; defect repair)	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	
Heart rhythm problem or palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Failure (congestive)	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged or weak heart	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	
Heart birth defect	<input type="checkbox"/>	<input type="checkbox"/>	
Heart valve problem	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	
Pericarditis (inflammation around heart)	<input type="checkbox"/>	<input type="checkbox"/>	
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____ #years
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____ #years

Past HEART testing **NO** **YES** **Date, Place, Doctor**

Arteriogram (heart cath, angiogram)	<input type="checkbox"/>	<input type="checkbox"/>	
Echocardiogram (ultrasound via chest)	<input type="checkbox"/>	<input type="checkbox"/>	
or TEE (ultrasound done via throat)	<input type="checkbox"/>	<input type="checkbox"/>	
Nuclear stress test (Cardiolite, thallium)	<input type="checkbox"/>	<input type="checkbox"/>	
Stress test, treadmill or medicine stress test	<input type="checkbox"/>	<input type="checkbox"/>	
Heart monitor : 24 hour or 30-day	<input type="checkbox"/>	<input type="checkbox"/>	
EP study (catheter test for heart rhythm)	<input type="checkbox"/>	<input type="checkbox"/>	
PET scan of heart	<input type="checkbox"/>	<input type="checkbox"/>	
CT scan of heart	<input type="checkbox"/>	<input type="checkbox"/>	
MRI scan of heart	<input type="checkbox"/>	<input type="checkbox"/>	

List additional heart problems or test not listed above:

Heart Health Factors **NO** **YES**

Exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	_____ times per week
Ever smoked or used other tobacco ?	<input type="checkbox"/>	<input type="checkbox"/>	_____ packs per day
Quit smoking?	<input type="checkbox"/>	<input type="checkbox"/>	When? _____
Drink alcohol, beer or wine ?	<input type="checkbox"/>	<input type="checkbox"/>	_____ times per week
Use recreational drugs? (marijuana, cocaine)	<input type="checkbox"/>	<input type="checkbox"/>	_____ times per week
Fast food more than 2 times weekly ?	<input type="checkbox"/>	<input type="checkbox"/>	

MD initials _____

Patient Name _____ **Date** _____

Family & Life Information:

Marital status Married Single Separated Divorced Widowed
Children # _____ Ages _____
Work _____ # hrs/wk What type job? _____ Homemaker Retired Disabled
Education Elementary High school College

Family Medical History:

Check all relatives that have these problems **Mother** **Father** **Sister** **Brother** **Grandparent**

	Mother	Father	Sister	Brother	Grandparent
High blood pressure					
Stroke					
Diabetes					
High cholesterol					
Early sudden death					
Heart attack					
Heart surgery					
Heart rhythm problem / pacemaker					
Heart failure / weak heart / enlarged heart					

Other _____

Your PAST MEDICAL HISTORY: Have you ever been diagnosed with or treated for any of the following problems?

NO **YES** **Explain any treatment or surgery with dates, doctors & hospitals**

	NO	YES	Explain any treatment or surgery with dates, doctors & hospitals
Stroke or mini stroke (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	
Neuropathy (decreased feelings in limbs)	<input type="checkbox"/>	<input type="checkbox"/>	
Aneurysm / poor circulation in legs, abdomen (aorta)	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery on blood vessels in neck (carotid)	<input type="checkbox"/>	<input type="checkbox"/>	
Brain aneurysm or bleed into brain	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Vision problems, near or farsighted	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses? NO YES
Lungs (asthma, emphysema, COPD)	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep apnea (stop breathing during sleep)	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Explain & List treating MD
Lived with anyone with TB in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	
Ever had a positive TB skin test ?	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal chest x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach or esophagus (reflux, ulcer, hiatal hernia)	<input type="checkbox"/>	<input type="checkbox"/>	
Bowels (hemorrhoids, diverticulitis, irritable bowel)	<input type="checkbox"/>	<input type="checkbox"/>	
Gallstones or gallbladder surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis? No Yes _____ times per week
Bladder problem	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate (enlarged or surgery)	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	

MD initials _____

Patient Name _____

Date _____

PAST HISTORY (continued)	NO	YES	Explain any treatment or surgery with dates, doctors & hospitals
Dental or gum problems or dentures	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle, bone, or joint problems	<input type="checkbox"/>	<input type="checkbox"/>	
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Rheumatoid</i> arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus or other immune disease	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS, HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clots to lung or in legs	<input type="checkbox"/>	<input type="checkbox"/>	
Free bleeder	<input type="checkbox"/>	<input type="checkbox"/>	
Thick blood, hypercoagulable, clots too quickly	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia , low blood count , unexplained	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Low or high blood platelet counts	<input type="checkbox"/>	<input type="checkbox"/>	
Blood transfusion or reaction to transfusion	<input type="checkbox"/>	<input type="checkbox"/>	
Gout	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	chemotherapy? No Yes: Current Completed
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar or manic depressive disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety or panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	

List other conditions & ALL SURGERIES , hospital stays & injuries not listed above (with the date & place)

SYMPTOMS (RECENT) : *In the past 6 months*, have you experienced the following ?

General	NO	YES		Genitourinary	NO	YES
Fevers (unexplained, frequent)	<input type="checkbox"/>	<input type="checkbox"/>		Urinary incontinence (leaking urine)	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>		Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Unplanned weight loss	<input type="checkbox"/>	<input type="checkbox"/>		Urination at night frequently	<input type="checkbox"/>	<input type="checkbox"/>
Unplanned weight gain	<input type="checkbox"/>	<input type="checkbox"/>		Burning with urination	<input type="checkbox"/>	<input type="checkbox"/>
Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>		Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia / difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>		Difficulty passing urine	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>		Men: Erectile dysfunction (impotence)	<input type="checkbox"/>	<input type="checkbox"/>
Double or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>		Women: Possibly pregnant? _____ wks	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>		Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat				Musculoskeletal		
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		Muscle weakness / pain /cramps	<input type="checkbox"/>	<input type="checkbox"/>
Ringin g in ears	<input type="checkbox"/>	<input type="checkbox"/>		Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>		Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained hoarseness	<input type="checkbox"/>	<input type="checkbox"/>		Neck , shoulder or arm pain	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>		Legs: Hurt / tire quickly with walking	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems/hay fever/allergies	<input type="checkbox"/>	<input type="checkbox"/>				

MD INITIALS _____

Patient Name _____ Date _____

SYMPTOMS (Recent) (continued)

Cardiovascular	NO	YES		Neurological / Emotions / Thoughts	NO	YES
Chest pain or pressure	<input type="checkbox"/>	<input type="checkbox"/>		Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pulse irregular, fast or slow	<input type="checkbox"/>	<input type="checkbox"/>		Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
Passed out or nearly passed out	<input type="checkbox"/>	<input type="checkbox"/>		Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>		Weakness in arm / leg	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath with activity or walking	<input type="checkbox"/>	<input type="checkbox"/>		Tingling in arms / legs	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath that wakes you at night	<input type="checkbox"/>	<input type="checkbox"/>		Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory / Lungs				Difficulty thinking, can't concentrate	<input type="checkbox"/>	<input type="checkbox"/>
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>		Dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>		Excessive anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		Unusual sadness	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal				Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/ vomiting / diarrhea frequently	<input type="checkbox"/>	<input type="checkbox"/>		Unusual irritability	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn , indigestion, reflux frequently	<input type="checkbox"/>	<input type="checkbox"/>				
Bleeding or painful hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>		Skin		
Blood in stool or black stool (BM)	<input type="checkbox"/>	<input type="checkbox"/>		Frequent rashes	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>		Sores that do not heal	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		Other skin problem (List)		
Frequent abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>				
Endocrine / Hematologic / Lymphatic						
Frequently feel very hot or cold	<input type="checkbox"/>	<input type="checkbox"/>		Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Unusually thirsty	<input type="checkbox"/>	<input type="checkbox"/>		Bleed or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>

List other symptoms below:

ALLERGIES: List ALL medicines, X-ray dyes, foods or products that give you problems

(Examples: sulfa , penicillin, codeine, tetanus shot , **IVP dye**, eggs, shellfish, latex)

Substance	Problem
<i>Example: Penicillin</i>	<i>Couldn't breath, lips swelled, cough , red rash , upset stomach</i>
<input type="checkbox"/> NONE	

MD Initials _____

