Saint Thomas Heart

1.800.345.5016 | www.SaintThomasHeart.com

Please answer all questions. List your name and the date on each page.

Name: ______________________ Date:______________
(LAST) (FIRST) (MI) (MM/DD/YYYY)

Age:________ Sex: M F Height: ______________ Weight:______________ BirthDate: ______________

Race: ____

Please list Physician/Provider that referred you:

Dr. ______________________________________ Phone: ______________

Reason for today's visit: (Please list all problems/concerns and when they started) ______________

____

____

YOUR HEART HISTORY & RISK FACTORS

Have you experienced any of the following conditions?

Circle "Y" for Yes or "N" for No. If Yes, explain with the year it took place and name of the doctor or hospital.

Condition				
Heart Attack	**Y/N**		If yes, year? ________	Who/Where? ______________
Angioplasty, Stent, Balloon, 'Roto-Rooter', etc.	**Y/N**		If yes, year? ________	Who/Where? ______________
Coronary *(Heart)* Bypass Surgery	**Y/N**		If yes, year? ________	Who/Where? ______________
Other Heart Surgery *(Valve Replaced; Defect Repair)*	**Y/N**		If yes, year? ________	Who/Where? ______________
Pacemaker *or* Defibrillator	**Y/N**		If yes, year? ________	Who/Where? ______________
Heart Rhythm Problem *or* Palpitations	**Y/N**		If yes, year? ________	Who/Where? ______________
Heart Failure *(Congestive)*	**Y/N**		If yes, year? ________	Who/Where? ______________
Enlarged Or Weak Heart	**Y/N**		If yes, year? ________	Who/Where? ______________
Heart Murmur	**Y/N**		If yes, year? ________	Who/Where? ______________
Rheumatic Fever	**Y/N**		If yes, year? ________	Who/Where? ______________
Heart Birth Defect	**Y/N**		If yes, year? ________	Who/Where? ______________
Heart Valve Problem	**Y/N**		If yes, year? ________	Who/Where? ______________
Mitral Valve Prolapse	**Y/N**		If yes, year? ________	Who/Where? ______________
Pericarditis *(Inflammation Around Heart)*	**Y/N**		If yes, year? ________	Who/Where? ______________
High Cholesterol	**Y/N**	______# Years?	If yes, year? ________	Who/Where? ______________
High Blood Pressure	**Y/N**	______# Years?	If yes, year? ________	Who/Where? ______________
Diabetes	**Y/N**	______# Years?	If yes, year? ________	Who/Where? ______________

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YOUR PAST HEART TESTING

Have you received any of the following tests?

Circle "Y" for Yes or "N" for No. If Yes, list the date it took place and name of the doctor or hospital.

Test	Y/N	Date	Who/Where
Arteriogram *(Heart Cath, Angiogram)*	**Y/N**	If yes, date? ________	Who/Where? ____________
Echocardiogram *(Ultrasound via Chest)*	**Y/N**	If yes, date? ________	Who/Where? ____________
TEE *(Ultrasound via Throat)*	**Y/N**	If yes, date? ________	Who/Where? ____________
Nuclear Stress Test *(Cardiolite, Thallium)*	**Y/N**	If yes, date? ________	Who/Where? ____________
Stress Test, Treadmill or	**Y/N**	If yes, date? ________	Who/Where? ____________
Medicine Stress Test	**Y/N**	If yes, date? ________	Who/Where? ____________
Heart Monitor *(24 Hr or 30-Day)*	**Y/N**	If yes, date? ________	Who/Where? ____________
EP Study *(Catheter Test for Heart Rhythm)*	**Y/N**	If yes, date? ________	Who/Where? ____________
PET Scan of Heart	**Y/N**	If yes, date? ________	Who/Where? ____________
CT Scan of Heart	**Y/N**	If yes, date? ________	Who/Where? ____________
MRI Scan of Heart	**Y/N**	If yes, date? ________	Who/Where? ____________

List additional heart problems or tests not listed above: ________________________________

____

____

____

HEART HEALTH FACTORS

Circle "Y" for Yes or "N" for No. If Yes, please circle or list the additional requested information.

Factor	Y/N	Question			
Exercise Regularly?	**Y/N**	How often per week?	**1–2 times**	**3–4 times**	**More than 4**
Ever Smoked/Used Tobacco ?	**Y/N**	If yes, what type?	**Smoke/Dip/Chew**	Have you quit? Year _______	
Drink Alcohol, Beer or Wine ?	**Y/N**	How many drinks per week?	**1–2**	**3–4**	**More than 4**
Use Recreational Drugs? *(i.e., Marijuana, Cocaine, etc.)*	**Y/N**	If yes, how often per week?	**1–2**	**3–4**	**More than 4**
Consume Fast Food?	**Y/N**	If yes, how often per week?	**1–2**	**3–4**	**More than 4**

M.D. Initials ____________

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FAMILY & LIFE INFORMATION

Marital Status: **Married / Single / Seperated / Divorced / Widowed**

Children: How many?__________ Ages? ______________ Education: **Elementary / High School / College**

Work: How many hours per week?__________ Type of job? __________________ **Homemaker / Retired / Disabled**

FAMILY MEDICAL HISTORY

Check all relatives that have any of these problems.

	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?

Circle “Y” for Yes or “N” for No. If Yes, explain any treatment/surgery, the date it took place and the doctor/hospital.

Stroke or Mini Stroke (TIA) **Y/N** If yes, date? _____________ Who/Where? ______________________________

Neuropathy **Y/N** If yes, date? _____________ Who/Where? ______________________________

Aneurysm **Y/N** If yes, date? _____________ Who/Where? ______________________________

Surgery on Blood Vessels in Neck **Y/N** If yes, date? _____________ Who/Where? ______________________________

Brain Aneurysm/Bleed into Brain **Y/N** If yes, date? _____________ Who/Where? ______________________________

Migraine Headaches **Y/N** If yes, date? _____________ Who/Where? ______________________________

Seizures **Y/N** If yes, date? _____________ Who/Where? ______________________________

Cataracts **Y/N** If yes, date? _____________ Who/Where? ______________________________

Glaucoma **Y/N** If yes, date? _____________ Who/Where? ______________________________

Vision Problems, Near/Farsighted **Y/N** Contact Lenses? **Y/N**

Lungs **Y/N** If yes, date? _____________ Who/Where? ______________________________
(Asthma, Emphysema, COPD)

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YOUR PAST MEDICAL HISTORY (CONTINUED)

Pneumonia or Bronchitis	Y/N	If yes, date? ________	Who/Where? ________________
Sleep Apnea	Y/N	If yes, date? ________	Who/Where? ________________
Tuberculosis (TB)	Y/N	If yes, date? ________	Who/Where? ________________
Lived w/anyone w/TB last 2yrs?	Y/N	If yes, date? ________	Who/Where? ________________
Ever had a positive TB skin test?	Y/N	If yes, date? ________	Who/Where? ________________
Abnormal Chest X-ray?	Y/N	If yes, date? ________	Who/Where? ________________
Stomach/Esophagus *(reflux, ulcer)*	Y/N	If yes, date? ________	Who/Where? ________________
Bowels *(hemorrhoids, diverticulitis)*	Y/N	If yes, date? ________	Who/Where? ________________
Gallstones/Gallbladder Surgery	Y/N	If yes, date? ________	Who/Where? ________________
Liver Disease	Y/N	If yes, date? ________	Who/Where? ________________
Hepatitis	Y/N	If yes, date? ________	Who/Where? ________________
Kidney Failure	Y/N	Dialysis? Y/N	If yes, times per week? ____________
Bladder Problem	Y/N	If yes, date? ________	Who/Where? ________________
Prostate *(Enlarged or Surgery)*	Y/N	If yes, date? ________	Who/Where? ________________
Hysterectomy	Y/N	If yes, date? ________	Who/Where? ________________
Skin Disorder	Y/N	If yes, date? ________	Who/Where? ________________
Dental/Gum Problems/Dentures	Y/N	If yes, date? ________	Who/Where? ________________
Thyroid Problems	Y/N	If yes, date? ________	Who/Where? ________________
Muscle/Bone/Joint Problems	Y/N	If yes, date? ________	Who/Where? ________________
Joint Replacement	Y/N	If yes, date? ________	Who/Where? ________________
Rheumatoid Arthritis	Y/N	If yes, date? ________	Who/Where? ________________
Lupus/Other Immune Disease	Y/N	If yes, date? ________	Who/Where? ________________
AIDS/HIV Positive	Y/N	If yes, date? ________	Who/Where? ________________
Blood Clots to Lung/Legs	Y/N	If yes, date? ________	Who/Where? ________________
Free Bleeder	Y/N	If yes, date? ________	Who/Where? ________________
Thick Blood/Hypercoagulable	Y/N	If yes, date? ________	Who/Where? ________________
Anemia/Low Blood Count	Y/N	If yes, date? ________	Who/Where? ________________
Sickle Cell Anemia	Y/N	If yes, date? ________	Who/Where? ________________

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YOUR PAST MEDICAL HISTORY (CONTINUED)

Low/High Blood Platelet Counts	Y/N	If yes, date? ________	Who/Where? ____________
Blood Transfusion/Reaction To	Y/N	If yes, date? ________	Who/Where? ____________
Gout	Y/N	If yes, date? ________	Who/Where? ____________
Cancer	Y/N	Chemotherapy? Y/N	If yes: **Current/Completed**
Depression	Y/N	If yes, date? ________	Who/Where? ____________
Bipolar/Manic Depressive Disorder	Y/N	If yes, date? ________	Who/Where? ____________
Anxiety/Panic Attacks	Y/N	If yes, date? ________	Who/Where? ____________

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

____

____

____

RECENT SYMPTOMS

In the past 6 months, have you experienced the following?

GENERAL

Fevers (Unexplained/Frequent)	Y/N
Night Sweats	Y/N
Unplanned Weight Loss	Y/N
Unplanned Weight Gain	Y/N
Excessive Fatigue	Y/N
Insomnia/Difficulty Sleeping	Y/N

EYES

Double/Blurred Vision	Y/N
Sudden Vision Loss	Y/N

EARS/NOSE/MOUTH/THROAT

Hearing Loss	Y/N
Ringing in Ears	Y/N
Frequent Nosebleeds	Y/N
Unexplained Hoarseness	Y/N
Trouble Swallowing	Y/N
Sinus Problems/Allergies	Y/N

GENITOURINARY

Urinary Incontinence	Y/N	
Frequent Urination	Y/N	
Frequent Night Urination	Y/N	
Burning w/Urination	Y/N	
Blood in Urine	Y/N	
Difficulty Passing Urine	Y/N	
Men: Erectile Dysfunction	Y/N	
Women: Possibly pregnant?	Y/N	________weeks
Heavy Periods	Y/N	

MUSCULOSKELETAL

Muscle Weakness/Pain/Cramps	Y/N
Joint Pain/Swelling	Y/N
Back Pain	Y/N
Neck/Shoulder/Arm Pain	Y/N
Legs Hurt/Tire Quickly Walking	Y/N

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RECENT SYMPTOMS (CONTINUED)

In the past 6 months, have you experienced the following?

CARDIOVASCULAR

Chest pain or pressure	Y/N
Pulse irregular, fast or slow	Y/N
Passed out or nearly passed out	Y/N
Swelling of legs	Y/N
Shortness of Breath w/Activity/Walking	Y/N
Shortness of Breath Wakes You at Night	Y/N

RESPIRATORY/LUNGS

Frequent cough	Y/N
Cough up blood	Y/N
Wheezing	Y/N

GASTROINTESTINAL

Nausea/ vomiting / diarrhea frequently	Y/N
Heartburn , indigestion, reflux frequently	Y/N
Bleeding or painful hemorrhoids	Y/N
Blood in stool or black stool (BM)	Y/N
Poor appetite	Y/N
Constipation	Y/N
Frequent abdominal pain	Y/N

SKIN

Frequent rashes	Y/N
Sores that do not heal	Y/N

Other Skin Problems (List): ________________

____

____

NEUROLOGICAL/EMOTIONS/THOUGHTS

Frequent headaches	Y/N
Poor coordination	Y/N
Numbness	Y/N
Weakness in arm / leg	Y/N
Tingling in arms / legs	Y/N
Loss of memory	Y/N
Difficulty thinking, can't concentrate	Y/N
Dizziness/vertigo	Y/N
Excessive anxiety	Y/N
Unusual sadness	Y/N
Hallucinations	Y/N
Unusual irritability	Y/N

ENDOCRINE/HEMATOLOGIC/LYMPHATIC

Frequently feel very hot or cold	Y/N
Unusually thirsty	Y/N
Enlarged lymph nodes	Y/N
Bleed or bruise easily	Y/N

List Any Symptoms Not Already Covered: ______________

____

____

____

____

____

ALLERGIES

List ALL Medicines, X-ray Dyes, and Foods/Products (i.e., Sulfa, Penicillin, Codeine, Eggs, Shellfish, Latex, etc.)

SUBSTANCE/PRODUCT ALLERGIC TO	PROBLEM/REACTION

M.D. Initials ______________

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MEDICATIONS

List **ALL** Prescribed/Over-the-Counter Medicines/Supplements/Vitamins/Herbs.

NAME	STRENGTH	# OF PILLS/TIMES PER DAY
Example: Lipitor	*40mg*	*One at Bedtime*

Is your family doctor aware of all of the above information? **Y/N**

The information I have listed is complete and accurate to the best of my knowledge.

Patient Signature ____ **Date** ________________

Name of person completing form if other than patient ____

MD Signature ____ **Date** ________________

REVIEWED AND UPDATED

DATE	MD	DATE	MD	DATE	MD	DATE	MD	DATE	MD	DATE	MD

M.D. Initials ______________