



NAME: _____ TODAY'S DATE: _____

REFERRING M.D.: _____ DATE OF BIRTH: _____ SEX: Male / Female

CHIEF COMPLAINT: _____

Reason for consultation: _____

1. Do you have now or have you ever had any of the following:

| Yes / No | | Yes / No | | Yes / No | | Yes / No | |
|----------|-------------------------|----------|--|----------|----------------------|----------|--------------------------|
| _____ | Shortness of breath | _____ | Chest Pain | _____ | Shaking | _____ | Frequent urination |
| _____ | Asthma | _____ | Slurred speech | _____ | Visual disturbance | _____ | Kidney problems |
| _____ | Fluid in lungs | _____ | Weakness | _____ | Loss of vision | _____ | Blood in urine |
| _____ | Wheezing | _____ | Stroke | _____ | Blurred vision | _____ | Arthritis |
| _____ | Emphysema | _____ | Fainting Spells | _____ | Double vision | _____ | Leg pain when walking |
| _____ | Bronchitis | _____ | Lightheadedness | _____ | Weight loss | _____ | Swelling of the ankles |
| _____ | Difficulty breathing | _____ | Headaches | _____ | Weight gain | _____ | Swelling of the legs |
| _____ | Chronic cough | _____ | Peptic ulcer | _____ | Excessive thirst | _____ | Varicose veins |
| _____ | Cough up blood | _____ | Constipation | _____ | Diabetes | _____ | Anxiety panic |
| _____ | High blood pressure | _____ | Liver disease | _____ | Thyroid | _____ | Depression |
| _____ | Irregular heart beat | _____ | Abdominal pain | _____ | Fatigue | _____ | Allergies |
| _____ | Rheumatic fever | _____ | Black stools | _____ | Easy bruising | _____ | Drug allergies |
| _____ | Heart murmur | _____ | Blood in stools | _____ | Bleeding disorder | _____ | Adverse drug reaction |
| _____ | Enlarged heart | _____ | Change in bowel habits | _____ | Congestion | _____ | Menstrual irregularities |
| _____ | Heart attack | _____ | Frequent bowel movements | _____ | Nose bleeds | _____ | Menopause (Date _____) |
| _____ | Palpitation | _____ | Cholesterol or lipid disorder | _____ | Burning on urination | _____ | Other _____ |
| _____ | Fluttering of the heart | _____ | Awakened at night by shortness of breath | | | | |

| PERSONAL AND FAMILY MEDICAL HISTORY | | | | | | PAST HISTORY: Have you ever had | | |
|-------------------------------------|------|--------|--------|----------|----------|--|--------|-------------------|
| | Self | Father | Mother | Siblings | Children | | Date | Location |
| Living or Deceased | | | | | | Cholesterol test | | |
| Age | | | | | | Lab Work | | |
| Anemia | | | | | | EKG | | |
| Arthritis | | | | | | Chest x-ray | | |
| Bleeding Disorder | | | | | | Exercise test | | |
| Cancer | | | | | | (with imaging) | | |
| Chest Pain | | | | | | Echocardiogram | | |
| Depression | | | | | | Cardiac Catheterization | | |
| Diabetes | | | | | | Pacemaker/ablation | | |
| Epilepsy / Seizures | | | | | | Cardiac surgery | | |
| Glaucoma | | | | | | | | |
| Gout | | | | | | | | |
| Headache/Migraines | | | | | | PAST HISTORY: Hospitalization (List with date & problem | | |
| Heart Disease | | | | | | Hospital | Date | Problem / Illness |
| Hepatitis | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| High Lipids | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Mental Illness | | | | | | | | |
| Prostate Disease | | | | | | | | |
| Rheumatic Fever | | | | | | SIGNIFICANT OPERATIVE OR INVASIVE PROCEDURES | | |
| Stroke | | | | | | Date | Reason | |
| Thyroid Disease | | | | | | | | |
| Ulcer | | | | | | | | |
| Other | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Updated April 3, 2014

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

| ADVERSE / ALLERGIC DRUG REACTIONS | |
|-----------------------------------|----------|
| Name of drug | Reaction |
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| MEDICATIONS (Include any herbal and over the counter medications) | | |
|---|--------|----------------------------|
| Name | Dosage | Directions / Times per day |
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| Social History: Habits / Risk Factors for Heart Disease |
|--|
| Smoke now? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Packs daily? _____ How long? _____ Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No Type? _____ Amount? _____ Controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No Type? _____ Stressful life style? <input type="checkbox"/> Yes <input type="checkbox"/> No Sedentary life style? <input type="checkbox"/> Yes <input type="checkbox"/> No Obesity? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you have an Advance Directive? Yes No
 Do you have a Living Will? Yes No

Disability Status and Dates: _____

- Office Abbreviations:
- | | |
|------------------------------------|---------------------|
| PSU → Patient stated understanding | C → Counseled |
| Δ → Change | D → Discussed |
| R → Refills | E → Exacerbation |
| M → Medications | S → Surgery |
| A → Advised | H → Hospitalization |
| Rx → medication therapy | R → Reviewed |

Physician Signature: _____

Date: _____

Update
04/03/2014