St David's Heart & Vascular

FOLLOW UP MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Appointment Date: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Primary Care Doctor: _____

Pharmacy (Name/Location/Phone): _____

REASON FOR VISIT:
- ☐ **Hospital follow up**
- ☐ **Surgery clearance**
- ☐ **Heart Issue** _____
- ☐ **Other** _____

DO YOU HAVE A LIVING WILL OR A MEDICAL POWER OF ATTORNEY? ☐ **YES** ☐ **NO**
HAVE YOU HAD THIS SEASON'S FLU IMMUNIZATION? ☐ **YES** ☐ **NO** **DATE:** _____
HAVE YOU HAD YOUR PNEUMONIA IMMUNIZATION? ☐ **YES** ☐ **NO** **DATE:** _____

☐ Check here if there are **NO** changes since your last visit

Any new ALLERGIES since your last visit? ☐ Yes ☐ No If yes, _____
Any SURGERIES since your last visit? ☐ Yes ☐ No If yes, _____
Any changes to FAMILY HISTORY since your last visit? ☐ Yes ☐ No If yes, _____
Any changes to SOCIAL HISTORY since your last visit? ☐ Yes ☐ No If yes, _____

A REVIEW OF YOUR CLINICAL SYSTEMS (Please check all that apply since your last visit)

What symptoms are you feeling today?

CONSTITUTION: Has there been a change in your ability to function as you normally do? ☐ Yes ☐ No
☐ Malaise/Fatigue ☐ Weight Gain ☐ Weight Loss

EYES: ☐ Vision Loss - Left ☐ Vision Loss - Right ☐ Visual Halos

RESPIRATORY: ☐ Cough ☐ Shortness of Breath ☐ Sleep Disturbance Due to Breathing ☐ Snoring ☐ Wheezing

SKIN: ☐ Skin Ulcers ☐ Poor Wound Healing

See back page

CARDIOVASCULAR: ☐ Chest Pain ☐ Claudication(Calf pain with walking) ☐ Leg Swelling
☐ Dyspnea on Exertion(Shortness of breathing with exertion)
☐ Orthopnea(Shortness of breath when lying down)
☐ PND (Attacks of shortness of breath that wake you)
☐ Palpitations(Irregular heartbeat)

ENDOCRINE: ☐ Intolerance of Cold ☐ Intolerance of Heat ☐ Polyuria(Frequent urination)

HEME/LYMPH: ☐ Bleeding ☐ Easy Bruising/Bleeding ☐ Clotting Tendency

MUSCULOSKELETAL: ☐ Arthritis ☐ Falls ☐ Joint Pain ☐ Muscle Cramps ☐ Muscle Weakness

GASTROINTESTINAL: ☐ Abdominal Bleeding ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn
☐ Melena(Dark tarry stool) ☐ Nausea ☐ Vomiting

GENITOURINARY: ☐ Hematuria(Blood in urine) ☐ Nocturia(Frequent nighttime urination)

NEUROLOGICAL: ☐ Daytime Sleepiness ☐ Dizziness ☐ Seizures ☐ Blackouts ☐ Vertigo ☐ Headaches

PSYCHIATRIC: ☐ Altered Mental Status ☐ Depression ☐ Memory Loss ☐ Anxiety or Nervousness

OTHER SYMPTOMS: _____

PATIENTS 65 YEARS OF AGE AND OLDER:

Have you fallen within the last three months? ☐ YES ☐ NO