St David's Heart & Vascular

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:** _____

ALLERGIES:
Have you had a reaction to X-Ray contrast dye? ☐ Yes ☐ No
Are you allergic to iodine or shellfish? ☐ Yes ☐ No
Are you allergic to any adhesives? ☐ Yes ☐ No
Are you allergic to any medications? ☐ Yes ☐ No If yes, _____

PAST MEDICAL HISTORY (Please indicate if you have been diagnosed with any of the following **by a physician**.)

- ☐ Arthritis
- ☐ A-Fib _____
- ☐ Anemia
- ☐ Angina
- ☐ Arrhythmia _____
- ☐ Asthma
- ☐ Syncope (passing out)
- ☐ Thyroid Disorder ◯ Low ◯ High
- ☐ Blood Clots in Veins or Lungs
- ☐ HIV
- ☐ AIDS
- ☐ Aneurysm
- ☐ Carotid Disease
- ☐ Heart Failure
- ☐ Clotting Disorder
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Cancer _____
- ☐ Cardiomyopathy
- ☐ COPD
- ☐ Liver Problems
- ☐ Anxiety
- ☐ _____
- ☐ Kidney disease
- ☐ Heart Attack
- ☐ Peripheral Arterial Disease (PAD)
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TIA
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Emphysema
- ☐ Hepatitis ☐ **A** ☐ **B or** ☐ **C**
- ☐ Depression
- ☐ _____

PAST SURGICAL HISTORY

- ☐ AAA Repair
- ☐ Cardiac Ablation
- ☐ ASD Repair
- ☐ Coronary Bypass
- ☐ Gall Bladder Removal
- ☐ Tonsils
- ☐ Vasectomy
- ☐ Hip Replacement ☐ Left ☐ Right
- ☐ Appendectomy
- ☐ Carotid Stenting
- ☐ Coronary Stenting
- ☐ ICD
- ☐ Pacemaker
- ☐ Hysterectomy
- ☐ Adenoids
- ☐ Carpal Tunnel Release
- ☐ Knee Replacement ☐ Left ☐ Right
- ☐ _____
- ☐ Peripheral Stenting
- ☐ Valve Repair/Replacement
- ☐ VSD Repair
- ☐ Cardioversion
- ☐ C-Section
- ☐ Fracture_____
- ☐ Cataract ☐ Left ☐ Right
- ☐ Knee Surgery _____
- ☐ _____

FAMILY HISTORY

☐ Adopted
☐ Family History Unknown

Relationship	Alive or Deceased?	A-Fib	Coronary Artery Disease	Clotting Disorder	Diabetes	Heart Attack	Heart Disease	Heart Failure	High Cholesterol	High Blood Pressure	Stroke	Other
Mother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(If writing in a grandparent or aunt/uncle, please specify maternal or paternal.)

YOUR SOCIAL HISTORY AND HABITS

Alcohol use, including beer: ☐ Yes ☐ No If yes, how many per day? _____

DRUG USE: Have you ever used intravenous drugs or cocaine? ☐ Yes ☐ No

Have you ever used other illegal drugs or been addicted to prescription pain medications? ☐ Yes ☐ No

If yes, explain _____

TOBACCO USE: ☐ Never Smoker

☐ Current Smoker

If current, _____ packs per day for _____ years

☐ Former Smoker

If former, quit date? _____

Do you have second-hand smoke exposure? ☐ Yes ☐ No

Currently use smokeless tobacco: ☐ CHEW ☐ SNUFF ☐ E-CIG

If previous tobacco user, _____ years. Quit date? _____

DO YOU EXERCISE REGULARLY? ☐ Yes ☐ No

CAFFEINE USE: How many caffeinated beverages do you drink per day (Coffee, soft drinks, tea)? _____

A REVIEW OF YOUR CLINICAL SYSTEMS (Please check all that apply)

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

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