

**Coastal Cardiology  
HEALTH HISTORY  
(Confidential)**

Name \_\_\_\_\_ Date \_\_\_\_\_ Referring Dr. \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Why are you seeing a cardiologist? \_\_\_\_\_

Coastal Cardiology Physicians Name you are seeing today: \_\_\_\_\_

**History and Physical – Please (X)**

**Heart problems or symptoms:**

- Heart Attack
- Angina
- Heart Murmur
- Rheumatic Fever
- Abnormal Rhythm (arrhythmia)
- Palpitations, irregular heartbeats
- Fainting
- Enlarge Heart
- Chest Pains or Pressure
- Shortness of Breath
- Dizziness
- Swollen Legs
- Heart Failure
- Blue Lips or Fingernails
- Leg Cramps when you walk

**Have you ever had:**

- A Stress Test (Treadmill)
- An Echocardiogram
- Cardiac Catheterization
- Coronary Angioplasty (balloon)
- Coronary Bypass Surgery
- Valve Surgery
- Electrophysiology Study/Proc.
- a Pacemaker
- Implanted Defibrillator
- ECG
- 24 Holter Monitor
- Event Recorder

**Check if you have:**

- High Blood Pressure
- High Cholesterol
- Ever Smoked
- Diabetes
- Do you exercise (walking)

**Close family member with:**

- Heart Attack
- Angina

**If a Woman have you:**

- Passed Menopause  
if so what age: \_\_\_\_\_
- Take Estrogen replacement

please tell us anything else about your heart: \_\_\_\_\_

**Current Medications:**

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_

**Allergies:**

Are you allergic to any medications?  Yes  No

List medications to which you are allergic: \_\_\_\_\_

What kind of reaction did you have? \_\_\_\_\_

**Past Medical History – Please (X) any symptoms you have or have had in the past year.**

**Constitutional**

- Lack of energy
- Trouble sleeping
- Loss of Appetite
- Weight changes
- Fever

**HEENT**

- Blurred vision
- Glaucoma
- Cataracts
- Buzzing or ringing in ears
- Hay fever
- Sinus Problem

**Respiratory**

- Wheezing
- Cough
- Coughing blood
- Asthma
- Tuberculosis

**Please complete - OVER**

**Please complete - OVER**

HEALTH HISTORY Continued:

Name: \_\_\_\_\_

**Digestive**

- Indigestion
- Change in bowel habits
- Bloody or tarry stools
- Jaundice
- Liver problems
- Ulcers
- Gallstones

**Dermatological**

- Rash
- Itching
- Other skin problems

**Neurological**

- Paralysis (even temporary)
- Stroke
- Numbness
- Loss of balance
- Dizziness

**Hematological**

- Bleeding
- Easy bruising
- Risk Factors for HIV
- Anemia
- Cancer

**Urinary**

- Frequency
- Infections
- Stones
- Bladder incontinence

**Men**

- Prostate problems
- Night-time urination

**Women**

- Abnormal Menstrual Periods
- Could you be pregnant?

**Musculoskeletal**

- Joint pain swelling or redness
- Arthritis
- Back pain
- Muscle aches
- Muscle tenderness
- Gout

**Female Reproductive**

- Breast lumps
- Recent mammogram
- Pap Smear &/or Pelvic Exam

**Psychiatric**

- Unusual thoughts
- Nervousness
- Crying or sadness
- Depression
- Suicide attempts

**Endocrinology**

- Thyroid disorder
- Diabetes
- Excess thirst
- Excess hunger
- Excess urination

**Have you had any operations?**

- 1) \_\_\_\_\_ 2) \_\_\_\_\_
- 3) \_\_\_\_\_ 4) \_\_\_\_\_

**Are you being treated now or have been treated for any illness?**

- 1) \_\_\_\_\_ 2) \_\_\_\_\_
- 3) \_\_\_\_\_ 4) \_\_\_\_\_

**Social History:**

**Marital Status:**  Single  Married  Widowed  Divorced

With whom do you live? \_\_\_\_\_

Occupation \_\_\_\_\_

Leisure Activities \_\_\_\_\_

Education Level \_\_\_\_\_

**Health Habits:**

Do you smoke?  Yes  No

How many packs per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

Do you use any drugs? \_\_\_\_\_

**Family History:**

Check if any close family members (parents, brothers and sisters, children) have:

- |  |                                 |                                 |                                  |                                 |                                |
|--|---------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |

Are there any other health problems in your family? \_\_\_\_\_

**Hospitalizations:**

Year	Hospital	Reason

**Please complete**