Coastal Cardiology
HEALTH HISTORY
(Confidential)

Name: ______________________________ Date: ____________________ Account#: ____________________

DOB: ___________________ Referring Physician: ____

Why are you seeing a cardiologist? ____

Which Coastal Cardiology physician are you 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
- ☐ Holter Monitor
- ☐ Event Recorder

Please tell us anything else about your heart: ____________________

____

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, at what age: ________
- ☐ Take Estrogen replacement

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 both sides of this form.

Continued Health History, Name:_______________________________

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

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

Dermatological
- [ ] Rash
- [ ] Itching
- [ ] Other skin problems

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

Psychiatric
- [ ] Unusual thoughts
- [ ] Nervousness
- [ ] Crying or sadness
- [ ] Depression
- [ ] Suicide attempts

Endocrinology
- [ ] Thyroid disorder
- [ ] Diabetes
- [ ] Excess thirst
- [ ] Excess hunger
- [ ] Excess urination

Hematological
- [ ] Bleeding
- [ ] Easy bruising
- [ ] Risk Factors for HIV
- [ ] Anemia
- [ ] Cancer

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:

☐ Heart Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child

Are there any other health problems in your family?_______________________________

Hospitalizations:

Year	Hospital	Reason

Please complete both sides of this form.