Coastal Cardiovascular Care
HEALTH HISTORY (Confidential)

Name:_____Date:_____Account#:_____
DOB:_____Referring Physician: _____
Why are you seeing a cardiologist? _____
Which Coastal Cardiologist 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

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

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

Continued Health History, Name:_____

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

Dermatological
- ☐ Rash
- ☐ Itching
- ☐ Other skin problems

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

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