PALM BEACH CARDIOLOGY PATIENT HISTORY FORM

Name: _____ **Sex:** _____ **Age:** _____ **Date:** _____

Date of birth: _____ **Email:** _____ **Social Security:** _____

Race/Ethnicity: _____

Address: _____ **Apt Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home #: (   ) _____ **Cell #: (   )** _____ **Business #: (   )** _____

Employer: _____ **Occupation:** _____

Spouse: _____ **Date of Birth:** _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Nearest Family Member not living with you _____ **Phone:** _____

Primary Insurance: _____ **Insurance Number:** _____

Secondary Insurance: _____ **Insurance number:** _____

Alternative Address: _____

Pharmacy: _____ **Phone(required):** _____

Lab: _____ **Phone(required):** _____

Referred by: _____ **Primary Care Dr.:** _____

Reason for visit: _____

Past Surgical History :

        Yes No

[ ] [ ] Coronary Artery Bypass Surgery (CABG)   Date: _____

[ ] [ ] Cardiac Cath/Angioplasty (Stent)   Date: _____

[ ] [ ] Heart Valve Surgery/Replacement   Date: _____

[ ] [ ] Organ Transplant _____   Date: _____

[ ] [ ] Tonsillectomy   Date: _____

[ ] [ ] Appendectomy   Date: _____

[ ] [ ] Musculoskeletal Surgery   Date: _____

[ ] [ ] Hysterectomy   Date: _____

[ ] [ ] Cataract Surgery   Date: _____

[ ] [ ] Peripheral Artery Surgery   Date: _____

[ ] [ ] Cholecystectomy (Gallbladder)   Date: _____

[ ] [ ] Mastectomy   Date: _____

[ ] [ ] Pacemaker/Defibrillator (brand)_____   Date: _____

[ ] [ ] Biventricular Device   Date: _____

[ ] _____   Date: _____

Allergies: [ ] Latex   [ ] Iodine/Shellfish   [ ] Tape   Reaction: _____

        _____   Reaction: _____

        _____   Reaction: _____

        _____   Reaction: _____

Patient Name_____ **Date of Birth**_____

Past Medical History

	Yes	No			Yes	No	
	[ ]	[ ]	Anemia		[ ]	[ ]	High Cholesterol
	[ ]	[ ]	Aortic Aneurysm		[ ]	[ ]	Hyperlipidemia
	[ ]	[ ]	Arrythmia		[ ]	[ ]	Hypertension (High Blood Pressure)
	[ ]	[ ]	Asthma		[ ]	[ ]	Kidney Disease
	[ ]	[ ]	Atrial Fibrillation (Afib)		[ ]	[ ]	Liver Disease
	[ ]	[ ]	Atrial Flutter		[ ]	[ ]	Lung Disease
	[ ]	[ ]	Blood Clot		[ ]	[ ]	Myocardial Infarction
	[ ]	[ ]	COPD		[ ]	[ ]	Neurologic Disorder
	[ ]	[ ]	CVA		[ ]	[ ]	Pacemaker
	[ ]	[ ]	Cancer		[ ]	[ ]	Palpitations
	[ ]	[ ]	Cardiomyopathy		[ ]	[ ]	Peptic Ulcer Disease
	[ ]	[ ]	Carotid Artery Disease		[ ]	[ ]	Peripheral Artery Disease
	[ ]	[ ]	Congenital Heart Disease		[ ]	[ ]	Renal Artery Stenosis
	[ ]	[ ]	Congestive Heart Failure (CHF)		[ ]	[ ]	Renal Insufficiency Disease
	[ ]	[ ]	Coronary Artery Disease		[ ]	[ ]	Sleep Apnea
	[ ]	[ ]	Deep Vein Thrombosis		[ ]	[ ]	Sleep Disorder
	[ ]	[ ]	Depression		[ ]	[ ]	Stroke
	[ ]	[ ]	Diabetes		[ ]	[ ]	TIA
	[ ]	[ ]	Gastrointestinal Disease		[ ]	[ ]	Thyroid Disease
	[ ]	[ ]	Genitourinary Disease		[ ]	[ ]	Valvular Abnormalities
	[ ]	[ ]	Heart Valve Disease (Murmur)		[ ]	[ ]	Valvular Heart Disease
	[ ]	[ ]	Hematologic Disease		[ ]	[ ]	Warfarin Management

Notes_____

Social History:

[ ] Single   [ ] Married   [ ] Divorced   [ ] Widowed

   [ ] Child(ren)   How Many?: ____

[ ] Tobacco Use   [ ] Never   [ ] Currently   [ ] Quit?   When did you quit? _____

                                                      Packs per day: ____   Years Smoking: _____

[ ] Caffeine Use   Drinks/day: ___

[ ] Alcohol Use   Drinks/day: ___

[ ] Drug Abuse   What Drug?: _____   [ ] Quit?

[ ] Under Excessive Stress   Explain: _____

Family History:

Father: Age: _____ [ ] Deceased?   Health problems: _____

Mother: Age: _____ [ ] Deceased?   Health problems: _____

Brothers: Age: _____ [ ] Deceased?   Health problems: _____

Sisters: Age: _____ [ ] Deceased?   Health problems: _____

Family history of: [ ] Heart Disease   [ ] Stroke   [ ] Bleeding Problems

Dietary History:

[ ] Low Salt   [ ] Low fat/cholesterol   [ ] Diabetic   [ ] Weight reduction

Exercise Regime:

[ ] Exercising Regularly   Times per week: _____   Type: _____

Patient Name_____   **Date of Birth**_____

Review of Systems(any history of the following)**:**

YES	NO		YES	NO	
[ ]	[ ]	Recent weight gain	[ ]	[ ]	Shortness of breath
[ ]	[ ]	Recent weight loss	[ ]	[ ]	Cough
[ ]	[ ]	Chills/Fevers/Night sweats	[ ]	[ ]	Coughing up blood
[ ]	[ ]	Fatigue/Malaise	[ ]	[ ]	Night sweats
[ ]	[ ]	Frequent/Persistant headaches	[ ]	[ ]	Wheezing
[ ]	[ ]	Blurry vision	[ ]	[ ]	Nausea/Vomiting
[ ]	[ ]	Nosebleeds/Bleeding gums	[ ]	[ ]	Diarrhea/Constipation
[ ]	[ ]	Neck pain/Stiffness	[ ]	[ ]	Black or tarry stools
[ ]	[ ]	Chest pain/Discomfort	[ ]	[ ]	Pain with urination
[ ]	[ ]	Palpitations	[ ]	[ ]	Frequent urination
[ ]	[ ]	Awaken short of breath	[ ]	[ ]	Blood in urine
[ ]	[ ]	Difficulty breathing, when _____	[ ]	[ ]	Skin cancer/Rashes
[ ]	[ ]	Swelling of ankles/feet	[ ]	[ ]	Excessive sweating/Thirst
[ ]	[ ]	Erectile difficulties (men)	[ ]	[ ]	Muscle aches/Joint pain
[ ]	[ ]	Leg pain when walking	[ ]	[ ]	Dizziness/Vertigo/Fainting
[ ]	_____		[ ]	[ ]	Neuropathy/Sensory disturbances
[ ]	_____		[ ]	[ ]	Anxiety/Depression
[ ]	_____		[ ]	_____	

Prior Testing:

Yes	No			
[ ]	[ ]	Echocardiogram	When: _____	Where: _____
[ ]	[ ]	Stress Test	When: _____	Where: _____
[ ]	[ ]	Cardiac Cath	When: _____	Where: _____
[ ]	[ ]	Carotid Ultrasound	When: _____	Where: _____