ADVANCED HEART CARE HISTORY & PHYSICAL

Name:_____ **DOB:**_____

Reason for Visit/ Chief Complaint: What symptoms or sensations have you been experiencing?

_____

_____

Chest Pains

- ❑ Chest pains
- ❑ Chest Tightness
- ❑ Chest Heaviness
- ❑ **ONLY** when you have chest pains do you have
  - ❑ Nausea
  - ❑ Vomiting
  - ❑ Shortness of breath
  - ❑ Sweaty/ Clammy
  - ❑ Neck Pain
  - ❑ Back Pain
  - ❑ Jaw Pain
  - ❑ Left Arm Pain
- ❑ How often?
  ___ Daily ____ Weekly ____ Monthly
- ❑ How long?
  ___ Secs ___ Mins ___Hrs ___Constant
- ❑ Is it with?
  ___ Rest ____ Exertion ____ Both

Cardiac Symptoms

- ❑ Dizzy Spells
- ❑ Passing out
- ❑ Palpitations
- ❑ Shortness of breath
  - ❑ Worse with activity
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Awaken in middle of night from sound sleep because of difficulty breathing
- ❑ Require pillows to sleep at nighttime or else you'll become short of breath
- ❑ Swelling in your hands and/or feet
- ❑ Leg cramps with activity

Past Surgical History (indicate the approximate date of each surgery)

- □ No prior surgery
- □ Cardiac Cath _____
- □ Angioplasty/PTCA _____
- □ Coronary Artery Bypass (Open Heart Surgery) _____
- □ Heart Valve Repair/replaced_____
- □ Carotid Artery Bypass _____
- □ Vascular Surgery _____
- □ Pacemaker _____
  What Brand?_____
- □ Defibrillator _____
  What Brand?_____
- □ Tonsillectomy/Adenoidectomy _____
- □ Appendectomy _____
- □ Cataract Removal _____
- □ Gallbladder _____
- □ Hernia Repair _____
- □ Splenectomy _____
- □ Aneurysm Repair _____
- □ Orthopedic (type: _____)
- □ Other: _____
- □ Other: _____
- □ Other: _____

Female Only

- ❑ Taken Premarin
- ❑ Hysterectomy
- ❑ Ovary(s) Removed
- ❑ C-Sections

Medications

If you have a list already or you brought your bottles with you, do not write them out.
Just bring the list /bottles to the nurse when you are called back

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

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Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Allergies

Any Known Allergies: □ No □ Yes (please list)_____

_____

_____

Past Medical History

□Blockage in your Heart	□Circulation Problems in Legs/arms	□High Cholesterol	□Sleep Apnea
□ Heart Attack	□Aneurysm in Abdomen	□High Blood Pressure	□Snoring
□Heart Failure	□Aneurysm in Brain	□Diabetes	□Rheumatic Fever
□Heart Murmur	□Blood Clotting Disorder	□Kidney Failure	□Scarlet Fever
□Leaky Heart Valves	□Blood Clots in Legs	□Gout	□Cancer
□Abnormal Heart Beat	□Blood Clots in Lungs	□Thyroid Problems	□Other _____
□Passing Out	□Stroke	□Asthma	
□Blockage in Neck	□Mini- Stroke	□COPD	

Tobacco, Alcohol and Drug History

❑ Do you smoke? □ no □ yes
If no: Did you ever smoke? □ no □ yes
What age did you start ? _____
How many years did you smoke? _____
How many packs per day did you smoke? _____
If yes: How many years have you been smoking? _____
How many packs per day do you smoke? _____

❑ Do you drink alcohol? □ no □ yes
If no: Did you ever drink alcohol? _____
How many drinks did you consume in an average week? _____
In what year did you stop consuming alcohol? _____
What did you typically drink?_____
If yes: How many drinks do you consume in an average week? _____
What do you typically drink?_____

❑ Do you use any illegal substances or recreational drugs? □ no □ yes
If no: Did you ever use? _____
How many times would you use in an average week? _____
In what year did you stop using? _____
What did you typically use?_____
If yes: How many times do you use in an average week? _____
What do you typically use?_____

Social History

What is your occupation?
_____

What is your marital status?
□ Single □ Separated
□ Married □ Widowed
□ Divorced

❑ Daily Caffeine Use:
- ❑ _____ Cups Coffee (6 oz)
- ❑ _____ Glasses Tea (8oz)
- ❑ _____Sodas (12 oz)

❑ Average Stress Level on a scale of 1-10 : _____
- ❑ Anxiety
- ❑ Depression
- ❑ OCD
- ❑ Bi-Polar

❑ Salt Use: ____High ____ Moderate _____Low

❑ Do you have advanced directive or living will: □ Yes □ No

How many times a week do you perform a formal exercise routine?
_____
What type of exercise program do you participate in? (please describe a typical exercise routine)_____
_____

What type of health conditions exist/existed in your… (blood relatives only)

Mother: □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Father: □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Sibling: □Brother □Sister □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Sibling: □Brother □Sister □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Sibling: □Brother □Sister □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Sibling: □Brother □Sister □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Sibling: □Brother □Sister □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Sibling: □Brother □Sister □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Sibling: □Brother □Sister □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Child: □Son □Daughter □ **Alive**; current age ____ □ **Deceased**; age at time of death ____
Health Conditions:____

Family Doctor:____________________________ **Referring Doctor:**_____________________________

Preferred Pharmacy:______________________ **Mail Order Pharmacy:**________________________