First and last name:_____ Date of birth:_____

PROVIDENCE HEART CLINIC – PATIENT HISTORY FORM

Today's Date: ____ / ____ / ____

CHIEF COMPLAINT – Briefly describe the main reason for your visit today:

_____

_____

Have you been diagnosed with? (Check any that apply)

Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐
Abnormal Heart Rhythm ☐ Murmur ☐ Coronary Artery Disease ☐
Abnormal EKG ☐ Abnormal Heart Valve ☐ Loss of Consciousness ☐

GENERAL HEALTH AND HABITS

EXERCISE

Do you exercise regularly? Yes____ No____
How long have you exercised on a regular basis? _____years
Type of exercises:_____ How Often? _____days/week for_____ minutes.

TOBACCO USE

Do you smoke? Yes____ Never____ Quit____ Do you use? Snuff____ Chew____
What do you smoke? Cigarettes____ Pipe____ Cigars____ Other (specify)
How many per day? _____ How many years? _____
If you no longer use tobacco, when did you quit? _____
If you no longer use tobacco, how long did you smoke and how many per day?_____

ALCOHOL/BEVERAGES

Do you drink alcohol? Yes____ No____ Rare ____
If yes, amount **per week**: Glasses of wine___ Cans of beer___ Shots if liquor___ Mixed drinks___
Did you formerly drink alcohol but have permanently stopped? Yes___ No___
Estimate the amount of caffeinated beverages (coffee, tea, cola) you drink **per day**: ____ glasses/cups/cans

DRUG USE

Do you use any? Anti-anxiety meds____ Amphetamines____ Barbiturates____ Cocaine____
Heroin___ Inhalants____ LSD____ Marijuana____ Methamphetamines____ Narcotics____
Nitrous oxide____ PCP____ IV____ Other:_____
If yes, how much per week?_____ How many years?_____
Method of ingestion: Injection_____ Smoke_____ Inhale_____

SOCIAL HISTORY

What is your marital status_____ If married, for how long?_____
Do you have any biological children? Yes____ No_____ If yes, how many _____
Are you currently employed? Yes_____ No_____ What is your occupation? _____
If no longer employed or retired, what was your occupation? _____

MEDICATIONS

Are you allergic to any medications or Iodine? Yes____ No____
If yes, please list the name and the reaction_____
_____
_____

Nursing staff must review your medications, vitamins and supplements at your appointment. Please bring all of your current medication bottles with you for accuracy.

MEDICATION LIST

Preferred Pharmacy_____

Medication	**Dose**	**Frequency** (Times per day)
EXAMPLE: Apixaban (Eliquis)	5 mg	One tablet 2 time a day

PAST MEDICAL AND SURGICAL HISTORY

Have you ever had sedation or anesthesia before? Yes No
If yes, list any problems?_____
Have you ever had IV contrast before? Yes No
If yes, list any problems? _____

Other Doctors- Please circle yes or no. If yes, provide name and phone number

Pulmonologist (Lung Doctor) **YES/NO** Name:_____ Phone:_____

2- Next page

First and last name:_____ Date of birth:_____

Nephrologist (Kidney Doctor)**YES** ☐ **NO** ☐ Name:_____ Phone:_____

Vascular Doctor (Circulation)**YES** ☐ **NO** ☐ Name:_____ Phone:_____

List all **surgeries** that you have had, date and hospital if known.

OPERATION	**HOSPITAL AND CITY**	**DATE**

List all **hospitalizations** not related to surgical procedures. **Do not include childbirth.**

REASON FOR HOSPITALIZATION	**HOSPITAL AND CITY**	**DATE**

FAMILY HEALTH: Have any of your family members been diagnosed with any of the following diseases? Specifically, any direst blood relative (mother, father, sister, brother). If yes, please (✓) which family member(s)

	Mother	Father	Sister	Brother	Daughter	Son	Other (Specify)
Arrhythmia							
Diabetes							
Disease of the Arteries or Veins							
Heart Attack							
Heart Failure							
High Cholesterol							
Hypertension (High Blood Pressure)							
Sudden Death							
Stroke							

Review of Systems Form

Do you **NOW** have any problems related to the following systems? If Yes, check it.

CONSTITUTIONAL	EYES	GASTROINTESTINAL	ENDO/HEME/ALLERGY
___ Fever	___ Blurred Vision	___ Heartburn	___ Easy bruise/bleed
___ Chills	___ Double vision	___ Nausea	___ Env allergies
___ Weight loss	___ Light sensitivity	___ Vomiting	___ Excessive thirst
___ Malaise/Fatigue	___ Eye pain	___ Abdominal pain	
___ Night sweats	___ Eye discharge	___ Diarrhea	
___ Weakness	___ Eye redness	___ Constipation	
		___ Blood in stool	
		___ Black in stool	

SKIN	CARDIOVASCULAR	GENITOURINARY	NEUROLOGICAL
___ Rash	___ Chest pain	___ Painful urination	___ Dizziness
___ Itching	___ Palpitations	___ Urgency	___ Tingling
	___ Shortness of breath while Laying flat	___ Frequency	___ Tremor
		___ Blood in urine	___ Sensory change
	___ Walking leg pain	___ Flank pain	___ Speech change
	___ Leg swelling		___ Focal weakness
	___ Shortness of breath that Awakens you from sleep		___ Seizures
			___ Fainting

HENT	RESPIRATORY	MUSCULOSKELETAL	PSYCHIATRIC
___ Headaches	___ Cough	___ Muscle pain	___ Depression
___ Hearing loss	___ Bloody mucus	___ Neck pain	___ Suicidal ideas
___ Ear ringing	___ Mucus production	___ Back pain	___ Substance abuse
___ Ear pain	___ Shortness of breath	___ Joint pain	___ Hallucinations
___ Ear discharge	___ Wheezing	___ Falls	___ Nervous/Anxious
			___ Insomnia
			___ Memory loss