# CARDIAC & THORACIC SURGERY SPECIALISTS

NEW PATIENT HEALTH HISTORY

Date of Visit: _____ Referring Physician: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: M/F

Primary Care Physician: _____ Cardiologist: _____

Oncologist: _____ Pulmonologist: _____

Pharmacy name and phone #: _____

## History of Present Illness:

_____

_____

_____

## Cardiac Related Medical History:

Please check all that apply and indicate the date the condition started:

| Yes | No | | Date |
|---|---|---|---|
| ☐ | ☐ | Hypertension (High blood pressure) | _____ |
| ☐ | ☐ | Diabetes ☐ Type I ☐ Type II | _____ |
| | | Diabetes Control: ☐ Diet ☐ Oral ☐ Insulin ☐ None | |
| ☐ | ☐ | High cholesterol | _____ |
| ☐ | ☐ | Coronary artery disease | _____ |
| | | ☐ Heart Attack | _____ |
| | | ☐ Coronary stent | _____ |
| | | ☐ Previous bypass surgery | _____ |
| ☐ | ☐ | Family History of Coronary artery disease | _____ |
| | | ☐ Male < 55 y.o. ☐ Female < 65 y.o. | _____ |
| ☐ | ☐ | Congestive Heart Failure (CHF) | _____ |
| ☐ | ☐ | Peripheral vascular disease | _____ |
| ☐ | ☐ | Cardiac Arrhythmia (atrial fibrillation) | _____ |
| ☐ | ☐ | Kidney Disease | _____ |
| | | ☐ Dialysis | _____ |
| ☐ | ☐ | Endocarditis | _____ |
| ☐ | ☐ | Syncope (passing out) | _____ |
| ☐ | ☐ | Stroke/ TIA | _____ |
| ☐ | ☐ | Carotid artery disease | _____ |
| ☐ | ☐ | Lung disease/ COPD | _____ |
| | | ☐ currently on home oxygen | _____ |
| ☐ | ☐ | Sleep Apnea ☐ CPAP | _____ |
| ☐ | ☐ | Pneumonia | _____ |
| ☐ | ☐ | Liver Disease | _____ |
| ☐ | ☐ | Cancer- Type: _____ Site: _____ | _____ |
| | | ☐ Radiation ☐ Chemotherapy ☐ Surgery | |

Patient Name: _____

## ALLERGIES:

Please list all medications to which you have an allergy or an adverse response and corresponding reaction

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## CURRENT MEDICATIONS:

Please list all medications prescription and non-prescription, including aspirin, vitamins, supplements, herbs, or appetite suppressants.

| Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Name: _____

Please list *ANY* previous surgeries/ procedures with approximate year below:

| Surgeries | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Other Medical History:

| | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Do you consent to the use of blood or blood products if necessary? ☐ Yes ☐ No

If no, please list religious or personal reason: _____

Previous Cardiovascular Pulmonary Testing:

| | | Location | Date |
|---|---|---|---|
| ☐ YES ☐ NO | Stress Test | | |
| ☐ YES ☐ NO | Echocardiogram | | |
| ☐ YES ☐ NO | Catherization/ angiogram | | |
| ☐ YES ☐ NO | Carotid Ultrasound | | |
| ☐ YES ☐ NO | CT Scan | | |
| ☐ YES ☐ NO | PET Scan | | |
| ☐ YES ☐ NO | Pulmonary function tests | | |

Patient Name: _____

## Family History

## Please place an "X" in any boxes that apply.

| Illness | Father | Mother | Brother | Sister | Grandfather | Grandmother | Son/s | Daughter/s |
|---|---|---|---|---|---|---|---|---|
| LIVING (Circle Y/N) | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| AGE | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Attack (list if known) | | | | | | | | |
| Other Heart Disease | | | | | | | | |
| Blood Clotting disorder | | | | | | | | |
| Stroke (list age if known | | | | | | | | |
| Lung Cancer | | | | | | | | |
| Breast Cancer | | | | | | | | |
| Other Cancer | | | | | | | | |
| Aortic Aneurysm | | | | | | | | |
| Sudden Death | | | | | | | | |

Patient Name: _____

## SOCIAL HISTORY:

Marital Status: □ Married □ Separated □ Divorced □ Widowed □ Single

Number of children: _____

Current hometown: _____

With whom do you live? _____

Who is at home to take care of you following surgery, or will you be residing elsewhere?

Please explain: _____

Current or Previous Occupation: _____

Are you retired? □ Yes □ No

How stressful is your job? □ None □ Mildly □ Moderately □ Very

List any hobbies: _____

Do you exercise? □ Yes □ No

If yes, describe how and how often: _____

Do you smoke? □ Yes □ Never Smoked □ Yes □ Former Smoker

How many packs of cigarettes do/did you smoke per day? _____

How many years have you smoked? _____ When did you quit? _____

Do you use smokeless tobacco? □ Yes □ No

□ Chew □ E-Cigarettes □ Snuff

Do you drink alcohol? □ Yes □ Never drank □ Former drinker

How much of the following did/do you drink in an average week?

_____ Glasses of wine _____ beers _____ drinks

When did you quit? _____

Do you consume caffeine? □ Yes □ No

How much in an average day do you consume of the following?

_____ Soda _____ Cups of Coffee _____ Glasses of Tea

Do you take illicit drugs or abuse prescription medications? □ Yes □ Never □ Former drug user

If yes, please specify: _____

[For office use] I have reviewed the above information with the patient: _____ (RN/ACNP/MA/LVN) _____ Date

Patient Name: _____

# REVIEW OF SYSTEMS

## Please circle any symptoms you are currently having.

### Constitution
Activity change
Appetite change
Chronic pain
Daytime sleepiness
Fatigue
Fever
Unexpected weight change

### H.E.N.T.
Congestion
Dental Problems
Hearing loss
Mouth sores
Nosebleeds
Heartburn
Snoring
Trouble Swallowing

### Eyes
Light sensitivity
Visual disturbance

### Respiratory
Apnea (stop breathing)
Chest tightness
Cough
Shortness of breath
Wheezing
Hemoptysis (Coughing up blood)

### Cardiovascular
Palpitations
Chest pain
Leg swelling

### GI
Abdomen swelling
Abdominal pain
Nausea
Vomiting
Diarrhea
Constipation
Blood in Stool
Difficulty swallowing
Painful swallowing

### Skin
Color Change
Pale skin
Skin change
Wound

### Endocrine
Cold intolerance
Heat intolerance
Excessive thirst
Excessive hunger
Excessive urination

### GU
Difficulty urination
Painful urination
Side pain
Frequent urination
Blood in urine
Nighttime urination
Urgency
Decreased urine

### Musculoskeletal
Joint aches
Back pain
Walking problem
Neck pain

### Allergy/ Immunology
Environmental allergies
Immunocompromised

### Neurological
Dizziness
Facial asymmetry
Headaches
Light- headedness
Numbness
Seizures
Speech difficulty
Fainting spells
Tremors
Weakness

### Hematologic
Enlarged Lymph nodes
Bruise/ bleed easily

### Psychiatric
Behavior problem
Confusion
Depressed mood
Nervous/ anxious
Severe stress
Sleep disturbance

[For office use] I have reviewed the above information with the patient: _____ (RN/ACNP/MA/LVN) _____ Date