UTAH CARDIOLOGY

Patient History

Name: _____ **DOB:** _____

Please complete this history form. If you have questions, please ask the nurse or doctor. Thank you.

Y	N	**Cardiac**
☐	☐	Chest Pain
☐	☐	Chest Pressure
☐	☐	Sweating
		Shortness of breath
☐	☐	while lying flat
☐	☐	Palpitation
☐	☐	Fainting
☐	☐	Near Fainting
☐	☐	Calf pain while walking
☐	☐	Swelling
☐	☐	Lower extremity sores
☐	☐	Varicose Veins

Y	N	**Constitutional**
☐	☐	Appetite Change
☐	☐	Chills/Rigors
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Insomnia
☐	☐	Night Sweats
☐	☐	Weight Gain
☐	☐	Weight Loss

Y	N	**Dermatologic**
☐	☐	Skin sensitive to light
☐	☐	Skin Sores/Rash

Y	N	**Endocrine**
☐	☐	Cold Intolerance
☐	☐	Excessive Perspiration
☐	☐	Hair Loss
☐	☐	Heat Intolerance
☐	☐	Tremors

Y	N	Hematologic
☐	☐	Easy Bleeding
☐	☐	Easy Bruising
☐	☐	Excessive Bleeding
☐	☐	Blood Clots

Y	N	**Ear**
☐	☐	Hearing Loss
☐	☐	Ringing in Ears
☐	☐	Dizzy w/ room spinning

		Nose & Sinus
☐	☐	Nose Bleeds

		Throat
☐	☐	Difficulty swallowing
☐	☐	Painful swallowing

Y	N	**Eyes**
☐	☐	Double Vision
☐	☐	Light sensitivity
☐	☐	Temporary Visual Loss
☐	☐	Visual Changes

Y	N	**Gastrointestinal**
☐	☐	Abdominal Pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Vomiting
☐	☐	Vomiting blood
☐	☐	Indigestion/Heartburn
☐	☐	Dark tarry stool
☐	☐	Nausea
☐	☐	Reflux

Y	N	**Genitourinary**
☐	☐	Cloudy Urine
☐	☐	Painful urination
☐	☐	Blood in urine
☐	☐	Incontinence
☐	☐	Urination at night
☐	☐	Frequent urination

		Reproductive - MALE
☐	☐	Erectile Dysfunction

Y	N	**Musculoskelatal**
☐	☐	Back Pain
☐	☐	Joint Pain
☐	☐	Knee Problems
☐	☐	Joint Stiffness
☐	☐	Muscle Cramps
☐	☐	Muscle Weakness
☐	☐	Muscle aches/pain

Y	N	**Neurological**
☐	☐	Balance Disturbance
☐	☐	Dizziness
☐	☐	Fainting (Syncope)
☐	☐	Headache
☐	☐	Memory Loss
☐	☐	Numbness in Extremities
☐	☐	Seizures
☐	☐	Tremors

Y	N	**Psychiatric**
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Hallucinations
☐	☐	Mood Swings
☐	☐	Sleep Disturbances
☐	☐	Suicidal Thoughts

Y	N	**Respiratory**
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Coughing up blood
☐	☐	Productive Cough
☐	☐	Snoring
☐	☐	Wheezing