UTAH CARDIOLOGY PC

PATIENT HISTORY FORM

Please complete all sections and bring this form with you to your appointment.
Please notify us in advance if we need to call and request labs, EKG's, records etc. from another provider.

Name: ______________________________ Date of Birth: ____________________

Physician You're Seeing: ____

Referring Physician: ____

Reason for Referral / Visit: ____

____

ALLERGIES **Do you have allergies to drugs, food, seafood, latex, dye?** ☐ YES ☐ NO

Allergy To	Reaction – rash, shortness of breath, hives, itching, etc.

CURRENT MEDICATIONS
Please list all vitamins, prescription medications and over-the-counter medications.

Medication Name	Dosage	How often do you take? *Once/day, Twice/day, Before meals etc.*	Prescribing Physician

PAST MEDICAL & SURGICAL HISTORY

EENT
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Sinusitus
- ☐ Tinnitus (Ears Ringing)
- ☐ Tonsilitis
- ☐ Other: _____

RESPIRATORY
- ☐ ARDS (Adult Resp. Distress Syndrome)
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolus (clot)
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea, CPAP
- ☐ Tuberculosis
- ☐ Other: _____

CARDIAC
- ☐ Arrhythmias
- ☐ Cardiomyopathy
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Myocardial Infarction (heart attack)
- ☐ Valvular Heart Disease
- ☐Other: _____

VASCULAR
- ☐ Aortic Aneurysm
- ☐ Carotid Disease
- ☐ Claudication
- ☐ DVT
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis
- ☐Raynaud's
- ☐ Varicose Veins
- ☐Other: _____

GASTROINTESTINAL
- ☐ Cirrhosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis
- ☐ Other: _____

RENAL/GU
- ☐ Bladder Cancer
- ☐ BPH (enlarged prostate)
- ☐ End Stage Renal Disease
- ☐ Kidney Stones
- ☐ Prostate Cancer
- ☐ Prostatitis
- ☐ Renal Artery Stenosis
- ☐ Renal Failure
- ☐ Renal Insufficiency
- ☐ Other: _____

GYN
- ☐ Benign Breast Lump
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Ovarian Cancer
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Gout
- ☐ Lupus
- ☐ MVA Trauma
- ☐ Rheumatoid Arthritis
- ☐ Other: _____

SKIN
- ☐ Cellulitis
- ☐ Hives
- ☐ Psoriasis
- ☐ Scleroderma
- ☐ Skin Cancer
- ☐ Other: _____

NEUROLOGIC
- ☐ Alzheimer's Disease
- ☐ CVA (stroke)
- ☐ Dementia
- ☐ Diabetic Neuropathy
- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Syncope
- ☐ TIA
- ☐ Other: _____

PSYCHIATRIC
- ☐ Alcoholism
- ☐ Anorexia
- ☐ Bipolar Disorder
- ☐ Chronic Anxiety
- ☐ Depression
- ☐ Panic Disorder
- ☐ Post Traumatic Stress Disorder
- ☐ Other: _____

HEMATOLOGIC
- ☐ Anemia
- ☐ Other: _____

INFECTIOUS DISEASE
- ☐ Endocarditis
- ☐ HIV
- ☐ Other: _____

RECENT HOSPITALIZATIONS ☐ YES ☐ NO

List Hospital/Date/Reason

_____

_____

_____

_____

CARDIAC SURGIES & PROCEDURES
- ☐ Cardiac Cath Year _____
- ☐ Cardioversion Year _____
- ☐ Cornary Angioplasty/Stent Year _____
- ☐ Coronary Artery Bypass (CABG) Year _____
- ☐ EP Study Year _____
- ☐ ICD Placement Year _____
- ☐ Pacemaker Implant Year _____
- ☐ RF Ablation Year _____
- ☐ Heart Valve Repair/Replaced Year _____
- ☐ Other: (List Below) Year _____

_____

_____

_____

_____

OTHER SURGERIES & PROCEDURES
- ☐ Aneurysm Repair Year _____
- ☐ Appendectomy Year _____
- ☐ Back Surgery Year _____
- ☐ Carotid Surgery Year _____
- ☐ Cholecystectomy (gallbladder removed) Year _____
- ☐ Thyroidectomy Year _____
- ☐ Hysterectomy Year _____
- ☐ Tonsillectomy Year _____
- ☐ Knee Surgery Year _____
- ☐ Mastectomy Year _____
- ☐ Other: _____ Year _____
- ☐ Other: _____ Year _____
- ☐ Other: _____ Year _____
- ☐ Other: _____ Year _____

SOCIAL & FAMILY HISTORY

Alcohol Use
Do you consume alcohol?
☐ YES ☐ NO ☐ Former
Frequency: _____
Year Quit: _____

Smoking/Tobacco Use
Do you smoke/use tobacco?
☐ YES ☐ NO ☐ Former
Type: ☐ Cigarettes ☐ Pipe
☐ Cigar ☐ Smokeless
Number of years smoked: _____
Packs per day: _____
Year Quit: _____
Age Quit: _____
Passive Smoke Exposure:
☐ YES ☐ NO

Diet
Are you on a special diet? ☐ YES ☐ NO
What type of diet? _____
_____
Do you drink caffeine? ☐ YES ☐ NO
How much per day? _____
Caffeine Type: _____
_____

Exercise
Do you exercise regularly? (besides daily activities)
(minimum of 30 minutes/3 time a week)
☐ YES ☐ NO
If YES, describe: _____
Religion: _____
Agree to Transfusion ☐ YES ☐ NO

Drug Use/Abuse
☐ YES ☐ NO ☐ FORMER
Substance Type: _____
Year Quit: _____
Marital Status: _____
Occupation
List: _____
☐ Unemployed ☐ Retired
Residence
Live With: _____
☐ Nursing Home ☐ Assisted Living
☐ Own Home
Advanced Directives
☐ None ☐ DNR
☐ HC Proxy
☐ Living Will Date: _____

Is there a Family History of: (List all Family Members) ☐ Family History Unknown

Heart Attack	☐ Yes	☐ No	Family Member _____
Stroke	☐ Yes	☐ No	Family Member _____
Coronary Bypass Surgery	☐ Yes	☐ No	Family Member _____
Diabetes	☐ Yes	☐ No	Family Member _____
High Blood Pressure	☐ Yes	☐ No	Family Member _____
Coronary Artery Disease	☐ Yes	☐ No	Family Member _____
Sudden Death	☐ Yes	☐ No	Family Member _____

REVIEW OF SYSTEMS *Check if you are experiencing any of the symptoms listed below:*

General
☐ Decrease appetite
☐ Fever
☐ Chills
☐ Weight change (Loss or Gain)
☐ Night Sweats
☐ Fatigue

HEENT
☐ Headache
☐ Glaucoma
☐ Cataracts
☐ Double vision
☐ Blurred vision
☐ Ringing in ears
☐ Hearing loss
☐ Hoarseness
☐ Nosebleeds

Respiratory
☐ Persistant cough
☐ Shortness of breath with rest
☐ Shortness of breath with activity
☐ Snoring
☐ Coughing up blood
☐ Wheezing
☐ # of pillows used to sleep on _____

Cardiovascular
☐ Chest pain, pressure or tightness
☐ Passing out
☐ Heart palpitations
☐ History of blood clots or phlebitis
☐ Irregular heart beats
☐ Non-healing sores on legs or feet
☐ Pain in legs/hips with walking
☐ Short of breath lying flat
☐ Swelling in feet or ankles
☐ Waking up panicky & short of breath
☐ Dizziness

Gastrointestinal
☐ Nausea and vomiting
☐ Nausea without vomiting
☐ Diarrhea
☐ Constipation
☐ Heartburn/Indigestion
☐ Rectal bleeding
☐ Black tarry stools
☐ Difficulty swallowing solids/liquids

Endocrine
☐ Excessive thirst
☐ Increased urination
☐ Hair loss

Hematological
☐ Bleed easily
☐ Bruise easily

Neurological
☐ Headaches
☐ Numbness/tingling on one side
☐ Weakness on one side
☐ Difficulty Speaking
☐ Loss of memory

Musculoskeletal
☐ Muscle weakness
☐ Joint Stiffness
☐ Arthritis
☐ Gout
☐ Muscle cramps

Genitourinary
☐ Blood in urine
☐ Pain with urination
☐ Frequency of urination
☐ Urgency of urination
☐ Incontinence

Males:
☐ Difficulty starting stream
☐ Wake up at night to urinate
☐ History of urinary retention
☐ Prostate problems
☐ Erectile dysfunction

Females:
Date of last menstrual period: _____
☐ Currently on birth control
Menopause: ☐ Yes ☐ No
Age at Menopause: _____

Patient Signature: _____ Date: _____

Signature of Person Completing Form: _____ Date: _____