ARKANSAS HEART HOSPITAL®
CLINIC

New Patient Visit Medical History

Name: ______________________________

Date of Birth: ______________________________

Date: ______________ Time: ______________

Please list the medications you are currently taking:

Medication Name	Strength	Dose	Frequency

Please List Any Allergies:

Name	Reaction	Name	Reaction
__Sulfa	______________	Penicillin	______________
__IV Dye	______________	__Latex	______________
______________	______________	______________	
______________	______________	______________	

Medical History

Have you ever had or been diagnosed with the following: (Please mark and specify)

	Year Diagnosed		Year Diagnosed
___Hypertension	________	___Blood Tranfusion	________
___Diabetes Insulin dependent	________	___Asthma	________
___Diabetes		___COPD	________
Non-Insulin dependent	________	___Seizures	________
___High Cholesterol		___Lupus	________
___Heart Attack	________	___Rheumatoid Arthritis	________
___Congestive Heart Failure	________	___Gout	________
___Atrial Fibrillation	________	___Cancer	
___Any Other Arrhythmias		Specify:__________	________
Specify______________	________	___Radiation Therapy	________
___Rheumatic Fever	________	___Chemotherapy	________
___Blood Clot In Legs	________	___Pancreatitis	________
___Blood Clot In Lungs	________	___Hepatitis	
___Aneurysm of Aorta	________	Type:__________	________
___Stroke TIA	________	___Kidney Failure	________
___Stroke CVA	________	___Require Dialysis	________
___Bleeding Tendency	________	___Osteoporosis	________
___Bleeding of the Stomach	________	___Polio	________
___Rectal Bleeding	________	___Hyperthyroidism	________
___Ulcer of the Stomach	________	___Hypothyroidism	________
___Chron's Disease	________	___Tuberculosis	________
___Diabetic Retinopathy	________	___Peripheral Vascular Disease	________

Surgical History

Have you ever had any of the following surgical procedures? (Please mark)

Type of Surgery	Year of Surgery	Where Performed
__Carotid Surgery	____________	_______________
__Heart Catheterization	____________	_______________
__Coronary Bypass	____________	_______________
__Heart Valve Surgery		
Which Valve_________	____________	_______________
__Appendix	____________	_______________
__Cholecystectomy (Gallbladder)	_________	_______________
__Hysterectomy	____________	_______________
__Mastectomy	____________	_______________
__Prostate Surgery	____________	_______________
__Varicose Vein Surgery	____________	_______________
__Cataract Surgery	____________	_______________
__Peripheral Bypass	____________	_______________
__Aneurysm Repair	____________	_______________

Have you ever had stents placed in any of the following:

	Year of Placement	Where Performed
__Coronary Artery	____________	_______________
__Renal Artery	____________	_______________
__Artery in Legs	____________	_______________
__Any Other Stents		
Specify_____________	____________	_______________

Hospitalizations

Please list any hospitalizations not related to above mentioned surgeries

When	Reason	Where
__________	___________________	_________________________________
__________	___________________	_________________________________
__________	___________________	_________________________________
__________	___________________	_________________________________

Family History

Has any immediate blood relative had any of these conditions:

___Unknown (Adopted)	Please List Relatives with each condition
___Diabetes	___________________________________
___Hypertension	___________________________________
___Coronary Artery Disease	___________________________________
___Heart Attack	___________________________________
___Vascular Disease	___________________________________
___Coronary Bypass	___________________________________
___Heart Disease before the age of 60	___________________________________
___Stroke/TIA	___________________________________
___Renal Failure	___________________________________
___Cancer(Specify):________________	___________________________________
___Arrhythmia	___________________________________

Father: __Living __Deceased If Deceased: Age at Death_____ Cause of Death_____________

Mother: __Living __Deceased If Deceased: Age at Death_____ Cause of Death_____________

Social History

Sex:________ Religion:_________________
Occupation:____
Marital Status:____________________ Health of Spouse:__________________
Number of Living Children: ________Girls ________Boys
With whom do you live?
___Alone ___Spouse ___Children ___Parents ___Other:__________

Are you currently using any of the following:
____Intravenous Street Drugs
____Amphetamines
____Cocaine
____Marijuana

Tobacco Use

Are you a (Circle One) Current Smoker Former Smoker Nonsmoker
If you are a 'current smoker' please answer the following:
How often do you smoke Cigarettes? ____Every Day ____Some days but not every day.
How many cigarettes a day do you smoke?
____5 or less ____ 6-10 ____11-20 ____21-30 ____31 or more
How soon after you wake up do you smoke your first cigarette?
____Within 5 min ____ 6-30mins ____31-60mins ____after 60mins
Are you interested in quitting?
____Ready to quit ____Thinking about quitting ____Not ready to quit
Do you use tobacco other than smoking? _____ Yes ____ No

Alcohol Use

Did you have a drink containing alcohol in the past year? ____Yes ____ No
If yes please answer the following questions:
How often did you have a drink containing alcohol in the past year?
___Never Monthly or less ____2-4 times a month ____2-3 times a week ____4 or more times a week
How many drinks did you have on a typical day when you were drinking in the past year?
___1-2 drinks ___3-4 drinks ___5-6 drinks ___7-9 drinks ___10 or more drinks
How often did you have 6 or more drinks on one occasion in the past year?
____Never ____Less than monthly _____monthly _____weekly ____daily or almost daily

Diet and Exercise

Do you consume caffeine? __Yes __No If Yes, How many cups per day?_________
Do you exercise? __Yes __No If Yes, How many times per week?________

Review of System

Please circle yes or no to any symptoms you are currently experiencing

General/Constitutional

Y N Weight Gain
Y N Weight Loss without Dieting
Y N Fatigue
Y N Fever
Y N Excessive Sweating
Y N Chronic Sense of Fatigue
Y N Night Sweats

HEENT (Eyes & Ears)

Y N Visual Disturbances
Y N Recent Vision Changes
Y N Hearing Loss or Recent Changes
Y N Nosebleeds
Y N Infected Teeth or Gums

Endocrine

Y N Mass in Neck/Goiter
Y N Uncontrolled Shaking or Tremors

Respiratory

Y N Snoring
Y N Coughing Up Blood
Y N Shortness of Breath with Activity
Y N Shortness of Breath without Activity
Y N Shortness of Breath when Lying Flat
Y N Frequent Cough
Y N Wheezing
Y N Stop Breath While Asleep

Cardiac

Y N Chest Pain/Chest Pressure
Y N Unpredictable Excessive Sweating
Y N Rapid Heart Rate
Y N Irregular Heart Rate
Y N Fainting
Y N Near Fainting
Y N Swelling
Location________________

Gastrointestinal

Y N Nausea
Y N Frequent Heartburn
Y N Black or Tarry Stools
Y N Vomiting
Y N Abdominal Pain
Y N Difficulty Swallowing
Y N Painful Swallowing
Y N Frequent Diarrhea
Y N Frequent Constipation

Hematology

Y N Low Blood Count
Y N Low Number of Platelets

Male Only

Y N Erectile Dysfunction
Y N Breast Enlargement

Female Only

Y N Are You Currently or Could You Be Pregnant
Y N Heavy Menstrual Bleeding
Y N Are you post menopause?
Y N Abnormal Bleeding?
Y N History of oral Contraceptives?

Genitourinary

Y N Blood in Urine
Y N Pain on Urination
Y N Difficulty Passing Urine

Musculoskeletal

Y N Joint Pain or Swelling
Y N Muscle Weakness
Y N Muscle Cramping
Y N Hernia
Y N Back Trouble
Y N Neck Trouble

Vascular

Y N Pain in Legs/ Calf While Walking
Y N Leg Swelling
Y N Redness or Discoloration of legs
Y N Cold Extremities
Y N Numbness/Burning in Feet

Skin

Y N Rash
Y N Itching
Y N Skin Sores
Y N Non-Healing Wounds

Neurological

Y N Dizziness
Y N Confusion
Y N Headaches
Y N One Sided weakness/numbness
Y N Memory Loss
Y N Seizures
Y N Slurred Speech

Psychiatric

Y N Untreated or Worsening Depression
Y N Untreated or Worsening Anxiety