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:

___Sulfa Reaction_____ Other_____

___IV Dye _____ _____

___Penicillin _____ Reaction_____

___Latex _____ _____

Medical History *Have you ever had or been diagnosed with the following? (Please mark and specify)*

	Year Diagnosed		*Year Diagnosed*
___Hypertension		___Blood Transfusion	
___Diabetes Insulin Dependent		___Asthma	
___Diabetes Non-Insulin Dependent		___COPD	
___High Cholesterol		___Seizures	
___Heart Attack		___Lupus	
___Congestive Heart Failure		___Rheumatoid Arthritis	
___Atrial Fibrillation		___Gout	
___Any Other Arrhythmias		___Cancer	
*Specify:*_____		*Specify:*_____	
___Rheumatic Fever		___Radiation Therapy	
___Blood Clot in Legs		___Chemotherapy	
___Blood Clot in Lungs		___Pancreatitis	
___Aneurysm of Aorta		___Hepatitis	
___Stroke TIA		*Specify Type:*_____	
___Stroke CVA		___Kidney Failure	
___Bleeding Tendency		___Require Dialysis	
___Bleeding of the Stomach		___Osteoporosis	
___Rectal Bleeding		___Polio	
___Ulcer of the Stomach		___Hyperthyroidism	
___Crohn'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	_____	_____
*Specify Which Valve:*_____		
___Appendectomy	_____	_____
___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 locations?

	Year of Placement	*Where Performed*
___Coronary Artery	_____	_____
___Renal Artery	_____	_____
___Artery in Legs	_____	_____
___Any other Stents	_____	_____
*Specify:*_____		

Hospitalizations *Please list any hospitalizations not related to the surgeries mentioned above.*

When	Reason	Where
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History *Has any immediate blood relative had any of these conditions?*

___Unknown (Adopted)
___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

Please list relatives with each condition:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 *Specify:*_____

Are you currently using any of the following?

___Intravenous Street Drugs
___Amphetamines
___Cocaine
___Marijuana

Tobacco Use

Are you a (Check 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

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 ___6-30 mins ___31-60 mins ___After 60 mins

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 per month ___2-3 times per week ___4 or more times per 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 Systems

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 (Head, Eyes, Ears, Nose, Throat)

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 Breathing 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 Pregnant or Could Be Pregnant
Y N Heavy Menstrual Bleeding
Y N Experiencing Menopause or 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