NORTH SHORE CARDIOLOGY CONSULTANTS
HEALTH HISTORY
(CONFIDENTIAL)

PATIENT NAME _____ TODAY'S DATE:
SEX: ×M ×F AGE: _____ BIRTH DATE: _____ Date of last physical examination:
Current HEIGHT: _____ WEIGHT: _____
MEDICATIONS *(list all medications you are currently taking)* _____

ALLERGIES: _____

(Please check (√) any symptoms you are currently having or have had in the past year)

CARDIOVASCULAR SYMPTOMS

□ Chest Pain
□ High blood pressure (hypertension)
□ Irregular heart beat
□ Low blood pressure (hypotension)
□ Palpitations
□ Poor circulation
□ Rapid heart beat
□ Swelling of ankles
□ Varicose veins

(Please check (√) if you have and any of the following procedures)

CARDIOVASCULAR PROCEDURES/SURGERIES

□ ANGIOPLASTY □ Coronary Artery □ Extremities
□ CABG (Coronary By-pass Surgery)
□ CAROTID ARTERY SURGERY (Endarterectomy)
□ CONGENITAL HEART SURERY
□ DEFIBRILLATOR
□ PACEMAKER
□ PERIPHERAL VASCULAR BY-PASS
□ STENT
□ VALVE REPLACEMENT
□ VALVE REPAIR
□ Other

(Please check (√) if you have and any of the following conditions)

CARDIOVASCULAR CONDITIONS

□ Aneurysm: □ Abdominal □ Cerebral □ Heart □ Thoracic
□ Arterial clot
□ Atrial septal defect
□ Cardiac arrhythmia
□ Cerebrovascular Accident (Stroke)
□ Congenital heart disease
□ Congestive heart failure
□ Deep vein thrombosis
□ Endocarditis/Pericarditis (inflammation of heart or valves)
□ Heart attack (myocardial infarction)
□ Heart Disease
□ Heart murmur
□ High blood pressure
□ High cholesterol
□ Mitral valve prolapse
□ Rheumatic Heart Disease
□ Rheumatic fever
□ Scarlet fever
□ TIA (Transient Ischemic Attack)
□ Valvular Heart Disease
□ Ventricular septal defect

(Please check (√) which substances you use and describe how much you use them. If you have quit please indicate the year you quit)

HEALTH HABITS

□ Alcohol _____
□ Caffeine _____
□ Drugs _____
□ Tobacco _____
□ Other _____

(Please describe the type of exercise and how often you exercise)

EXERCISE HABITS

□ Not at all
□ Rarely _____
□ Regularly _____
□ Frequently _____
□ Other _____

(Check (√) if your work exposes you to the following)

OCCUPATIONAL

□ Stress □ Hazardous Substances
□ Heavy lifting □ Occupation
□ Other _____

PERIPHERAL VASCULAR QUESTIONNAIRE *(Please circle the appropriate answer.)*

1. Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks when you walk or exercise? **Y** **N**
2. If you have answered yes to question number 1, does the pain subside with rest? **Y** **N**
3. Do you have numbness and tingling in the arms or lower legs and feet? **Y** **N**
4. Are your finger or toes pale, discolored or bluish? **Y** **N**
5. Are your hands or feet cold to the touch? **Y** **N**
6. Do you have any painful sores or ulcers on legs or feet that don't heal? **Y** **N**
7. Have you had any previous surgeries/procedures to your heart or blood vessels? **Y** **N**

   If YES, what procedure was performed? _____

   When was that procedure performed? _____

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION AND OUTCOME

SERIOUS ILLINESS/INJURY	DATE(S)	OUTCOME

Have you ever had a blood transfusion? □YES □NO If YES, please give the approximate year _____

FAMILY HISTORY

RELATION	AGE	STATE of HEALTH	AGE at DEATH	CAUSE of DEATH
Father				
Mother				
Brother(s)				
Sister(s)				

Please (√) if your blood relatives have had any of the following:

(√)	DISEASE	RELATIONSHIP TO YOU
	Arthritis Gout	
	Asthma, Hay fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Stroke	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

(Please check (√) symptoms or conditions you currently have or have had in the past year.)

GENERAL
□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of Sleep
□ Loss of Weight
□ Nervousness
□ Numbness
□ Sweats

GASTROINESTINAL
□ Appetite poor
□ Bloating
□ Bowel changes
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal bleeding
□ Stomach Pain

MUSCLE/JOINT/BONE
□ Pain, weakness, numbness in: □ Arms □ Back □ Hands □ Hips □ Feet □ Legs □ Neck □ Shoulders

SKIN
□ Bruise easily
□ Hives
□ Itching
□ Change in moles
□ Rash
□ Scars
□ Sore that won't heal

EYE, EAR, NOSE & THROAT
□ Bleeding Gums
□ Blurred Vision
□ Crossed Eyes
□ Difficulty swallowing
□ Double Vision
□ Earache
□ Hay fever
□ Hoarseness
□ Loss of hearing
□ Nosebleeds
□ Persistent cough
□ Ringing in the ears
□ Sinus problems
□ Vision – flashes
□ Vision – halos
□ Vision disturbances

GENITO-URINARY
□ Blood in urine
□ Frequent urination
□ Lack of bladder control
□ Painful urination

MEN ONLY
□ Breast lump
□ Erection difficulties
□ Lump in testicles
□ Penis discharge
□ Prostate problem
□ Sore on penis

WOMEN ONLY
□ Abnormal Pap Smear
□ Bleeding between periods
□ Breast lump
□ Extreme menstrual pain
□ Hot flashes
□ Miscarriage
□ Nipple discharge
□ Painful intercourse
□ Vaginal discharge
□ Vaginal infections
□ Other
Date of last menstrual period _____
Date of last mammogram _____
Are you pregnant?
□ Yes □ No
Number of children _____
Complications during Pregnancy _____
_____
_____
_____

CONDITIONS
(Please (√) if you have or have had any of the following)
□ Alcoholism
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding disorders
□ Breast lump
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical dependency
□ Chicken pox
□ Diabetes
□ Emphysema (COPD)
□ Epilepsy
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Hepatitis
□ Hernia
□ Herpes
□ HIV Positive
□ Kidney Disease
□ Liver Disease
□ Lung Disease
□ Measles
□ Migraine headaches
□ Mononucleosis
□ Multiple sclerosis
□ Mumps
□ Pneumonia
□ Polio
□ Psychiatric care
□ Stroke, mini stroke
□ Suicide attempt
□ Thyroid problems
□ Tonsillitis
□ Tuberculosis
□ Typhoid Fever
□ Ulcers