

**PATIENT HISTORY INTAKE – CARDIOLOGY / CARDIOVASCULAR**

**REVIEW OF SYSTEMS HISTORY - Do you have any of the following signs and/or symptoms?**

PLEASE MARK ( X ) IF ANY OF THE FOLLOWING APPLY TO YOU <u>CURRENTLY</u> , IN THE <u>PAST</u> OR <u>NEVER</u>				
GENERAL HEALTH	CURRENTLY	PAST	NEVER	List Other Signs or Related-Symptoms
Healthy Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss or Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fever last over 5 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lethargy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>EYES</b>				
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>EARS, NOSE, THROAT &amp; MOUTH</b>				
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems or Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>CARDIO / PERIPHERAL VASCULAR</b>				
Chest Pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular heart rhythms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Color changes in Lips or Tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling around eyes, hands or Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>RESPIRATORY</b>				
Coughing or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rapid breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GASTROINTESTINAL</b>				
Abdominal Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Black or Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heartburn or Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>URINARY</b>				
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>MUSCULOSKELETAL</b>				
Muscle aches / pains / weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bone aches / pains / weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>SKIN / BREAST</b>				
Masses / Lumps or Rash / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NEUROLOGICAL</b>				
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Forgetfulness or Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>PSYCHIATRIC</b>				
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety / Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ENDOCRINE</b>				
Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>HEMATOLOGIC / LYMPHATIC</b>				
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**NURSE NOTE:**

**PAST MEDICAL AND SURGICAL HISTORY**

<b>Prescription &amp; OTC Drugs - Name / Dosage / Frequency</b>		<b>Any Drug or Food Allergies?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known	
		List Drug or Food:	
<b>Operations / Hospitalizations – Reason</b>	<b>Date</b>	<b>Operations / Hospitalizations – Reason</b>	<b>Date</b>

**PATIENT’S PAST MEDICAL AND FAMILY HISTORY**

PLEASE INDICATE IF YOU OR A RELATIVE - (M) =MOTHER / (F) =FATHER / (S) =SIBLING / (GP) =GRAND PARENT – WAS AFFECTED BY CONDITION

<b>Condition</b>	<b>You</b>	<b>Relatives</b>	<b>Condition</b>	<b>You</b>	<b>Relatives</b>
Anemia			High Cholesterol or Triglycerides		
Blood Clot or Bleeding Disorder			Kawasaki Disease		
Congenital Heart Disease (Born With)			Mitral Valve Prolapse		
Deaf from Birth (Neuronal)			Rheumatic Fever		
Diabetes - <input type="checkbox"/> Type I <input type="checkbox"/> Type II			Stroke or Mini-strokes (TIA)		
Heart Murmur			Unexplained death in young		
Heart Attack / MI			Thyroid Problems		
High Blood Pressure			Other Cardio-Vascular Disease		