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 **CURRENTLY**, IN THE **PAST** OR **NEVER**

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

NURSE NOTE:

PAST MEDICAL AND SURGICAL HISTORY

Prescription & OTC Drugs - Name / Dosage / Frequency		***Any Drug or Food Allergies?*** ☐ Yes ☐ No ☐ Not Known	
		List Drug or Food:	
Operations / Hospitalizations – Reason	***Date***	***Operations / Hospitalizations – Reason***	***Date***

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

Condition	***You***	***Relatives***	***Condition***	***You***	***Relatives***
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 - [] Type I [] 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		