

SDCVA NEW PATIENT HISTORY FORM

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Marital Status: _____ Single: _____ Married _____ Widower/Widow _____

Where were you born _____ Level of Education _____

What is the reason for your visit today? _____

PAST MEDICAL HISTORY:

Have you ever had or been treated for the following diseases:? Please circle yes or no.

Rheumatic Fever yes/no If yes, at what age? _____

Heart Murmur yes/no What year was this first noted? _____

Heart Attack yes/no Dates _____

High Cholesterol yes/no How many years _____ Level _____

High Triglycerides yes/no How many years _____ Level _____

High Blood Pressure yes/no How many years _____

Diabetes yes/no How many years _____

Controlled by: Diet Pills Insulin

Have you ever had the following tests performed, please answer yes or no

Heart Catheterization yes/no Date _____ Place _____

Angioplasty yes/no Date _____ Place _____

Heart Surgeries yes/no Date _____ Place _____

Treadmill yes/no Date _____ Place _____

Echocardiogram yes/no Date _____ Place _____

Nuclear stress test yes/no Date _____ Place _____

Other Cardiac Studies (M U GA, etc.) Date _____ Place _____
yes/no

PREVIOUS SURGERIES:

Patient Name: _____

Type of Surgery

Place

Date

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAJOR ILLNESS OR INJURIES:

Reason for Admission

Place

Date

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL HABITS:

Do you or have you ever smoked or chewed tobacco? _____ Yes _____ No

If yes:

Cigarettes	_____ Yes _____ No	_____ pack/day for	_____ years	Date Stopped	_____
Cigars	_____ Yes _____ No	_____ pack/day for	_____ years	Date stopped	_____
Pipe	_____ Yes _____ No	_____ pack/day for	_____ years	Date stopped	_____
Chew	_____ Yes _____ No	_____ pack/day for	_____ years	Date stopped	_____

Do you or have you ever consumed alcohol? _____ Yes _____ No

If yes:

Casual	Daily	Excessive	Amount	_____
Caffeine: Casual	Daily	Excessive	Amount	_____

Any type of special diet required: _____

Exercise: _____

Do you enjoy your work or retirement? _____

Do you have difficulty falling asleep? _____

MEDICATIONS:

List below all medications, vitamins, laxatives. etc., that you have taken regularly during the past month. If the name of the medications is not known, please find the name from your pharmacist. Bring all medications with you.

Name & Dosage	Purpose Taken	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS, CONTINUED

Patient Name: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:

Drug or other allergy

Reactions

_____	_____
_____	_____
_____	_____

Are you allergic to contrast dye or iodine? If so list reaction _____

FAMILY HISTORY

Mother:

Father:

If living: Her age _____ years

If living: Her age _____ years

History of heart disease: ____yes ____no

History of heart disease: ____yes ____no

If yes: What age diagnosed: _____

If yes: What age diagnosed: _____

Health:

Health:

If deceased: Age at death _____ years

If deceased: Age at death _____ years

Cause: _____

Cause: _____

Living Brother or Sister:

Patient Name: _____

Age: _____ Sex: _____ Health: _____
Heart Disease Yes _____ No ____ What age diagnosed? _____

Age: _____ Sex: _____ Health: _____
Heart Disease Yes _____ No ____ What age diagnosed? _____

Age: _____ Sex: _____ Health: _____
Heart Disease Yes _____ No ____ What age diagnosed? _____

Age: _____ Sex: _____ Health: _____
Heart Disease Yes _____ No ____ What age diagnosed? _____

Age: _____ Sex: _____ Health: _____
Heart Disease Yes _____ No ____ What age diagnosed? _____

Children: Yes _____ No ____ How many? _____

Patient Name: _____

ARE YOU EXPERIENCING THE FOLLOWING PROBLEMS?

Circle Yes and No to each question.

- | | | |
|-----|----|--|
| Yes | No | Do you frequently have severe headaches? (If yes answer the following) |
| Yes | No | Do they cause visual trouble? |
| Yes | No | Do they feel like a tight band? |
| Yes | No | Does aspirin relieve them? |
| Yes | No | Do they occur on one side of your head? |
| Yes | No | Do they awaken you at night from sleep? |
| Yes | No | migranes? |

Have you ever experienced?

- | | | | | | |
|-----|----|---|-----|----|--------------------------------|
| Yes | No | tremors? | Yes | No | conjunctivitis? |
| Yes | No | spells of dizziness or motion sickness? | Yes | No | double vision/vision change? |
| Yes | No | fainting spell? | Yes | No | ringing in the ears? |
| Yes | No | spells of weakness of an arm or leg? | Yes | No | severe change in hearing? |
| Yes | No | seizures/convulsions? | Yes | No | nosebleeds? |
| Yes | No | pain or drainage in the ears? | Yes | No | abnormality of taste or smell? |
| Yes | No | gland swelling or lumps in the neck? | Yes | No | serious allergy symptoms |
| Yes | No | do you have a chronic cough or sore throat? | Yes | No | severe persistent dry mouth? |
| Yes | No | a stroke | Yes | No | Tia/mini-stroke? |

Do you frequently have...?

- | | | | | | |
|-----|----|---|-----|----|--------------------------------------|
| Yes | No | bleeding gums or serious dental problems? | Yes | No | trouble swallowing? |
| Yes | No | sore tongue or white patches? | Yes | No | hoarseness/significant voice change? |
- Patient Name: _____

Have you ever had shortness of breath?

- | | | | | | |
|-----|----|------------------------------|-----|----|---|
| Yes | No | doing your usual work? | Yes | No | which causes you to cough? |
| Yes | No | climbing a flight of stairs? | Yes | No | accompanied by wheezing? |
| Yes | No | which awakens you at night? | Yes | No | Do you sleep with more than one pillow? |

Have you ever had...?

- | | | | | | |
|-----|----|-------------------------------|-----|----|-------------------------|
| Yes | No | pleurisy? | Yes | No | do you cough up sputum? |
| Yes | No | do you have a chronic cough ? | Yes | No | do you cough up blood? |
| Yes | No | blood clot in your lungs? | Yes | No | asthma? |
| Yes | No | tuberculosis? | Yes | No | pneumonia? |
| Yes | No | COPD/emphysema? | Yes | No | bronchitis? |

Have you ever had chest pain or tightness on the chest...

- | | | | | | |
|-----|----|---|-----|----|--------------------------------------|
| Yes | No | when exerting yourself? | Yes | No | when upset or excited? |
| Yes | No | when walking up hill? | Yes | No | that disappears if you rest? |
| Yes | No | after a heavy meal? | Yes | No | which only occurs at rest? |
| Yes | No | which radiates down your arm/into neck? | Yes | No | do you have palpitations? |
| Yes | No | when walking fast? | Yes | No | do you have an irregular heart beat? |

Have you recently had pain in the stomach which...

- | | | | | | |
|-----|----|--|-----|----|----------------------------------|
| Yes | No | occurs after eating fried foods/gassy foods? | Yes | No | occurs 1-2 hours after a meal? |
| Yes | No | occurs while eating or immediately after? | Yes | No | awakens you at night? |
| Yes | No | is relieved by a bowel movement? | Yes | No | causes loss of appetite? |
| Yes | No | is relieved by antacid medications? | Yes | No | is relieved with milk or eating? |

Patient Name: _____

Have you had...

Yes No bleeding ulcer?
Yes No nausea and vomiting?
Yes No black stools?
Yes No diarrhea/loose stools?
Yes No colonoscopy?
Yes No trouble urinating?
Yes No kidney stones?
Yes No hepatis?

Yes No loss of bladder control?
Yes No blood in your stools?
Yes No vomited blood?
Yes No constipation?
Yes No endoscopy?
Yes No prostate problems?
Yes No kidney problems?
Yes No jaundice?

Have you had...

Yes No weight loss?
Yes No fever chills or night sweats?

Yes No weight gain?

Have you had...

Yes No pain in calves when walking?
Yes No cramps in the legs at night?
Yes No blood clots in your legs?
Yes No varicose veins?

Yes No swelling in the ankles/feet?
Yes No gout?
Yes No phlebitis?
Yes No arthritis?

Have you had...

Yes No severe dry or oily skin?
Yes No hair/nail change?
Yes No shingles?

Yes No skin lumps/rash/itching?
Yes No skin cancer?

Have you had...

Yes No thyroid disease?

Yes No goiter?

Have you had...

Yes No Depression?
Yes No Suicide attempt?

Yes No Anxiety?

Have you had...

Yes No bleeding tendency?
Yes No cancer?

Yes No Leukemia?
Yes No blood transfusion?

Other information: _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____