CARDIAC & VASCULAR CENTER
OF NORTH TEXAS

MEDICAL HISTORY

Initial Office Visit

Date of Service_____

Patient Name_____ Name You Wish to be Addressed By_____

Date of Birth_____ Primary Care Physician_____

Age_____ Sex ___Male ___ Female MD Requesting Visit_____

Welcome to the Cardiac & Vascular Center of North Texas.
We are pleased to have you as a new patient and hope that your experience with us is a pleasant one. We strive to provide you with the highest quality of care. In doing so, our cardiologists and physician extenders need to have the most comprehensive history possible. Please complete the following questions to the best if your ability.

Thank you.

The Cardiologists and Staff
Cardiac & Vascular Center of North Texas

Reason for Visit/ Chief Complaint: (why is it that you need or want to see a heart specialist? What symptoms or sensations have you been experiencing?)

_____

_____

History of Present Illness: (for physician use)

Location
Severity
Quality
Alleviation
Duration
Associated Sx
Timing

Past Medical History: (Please place a check mark by any condition that you have now or have had in the past)

Cardiac/Vascular

- ☐ Aneurysm
- ☐ Angina/Chest pain
- ☐ Aortic Aneurysm
- ☐ Arrhythmia
- ☐ Atrial Fibrillation or flutter
- ☐ Carotid Artery Disease
- ☐ Cardiomyopathy
- ☐ Claudication
- ☐ Congestive Heart Defect (Born with)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ DVT/Deep Vein Thrombosis
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pericarditis
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ TIA (mini-stroke or Temporary Stoke)
- ☐ Varicose Veins
- ☐ Other:_____

Endocrine

- ☐ Adrenal Gland disorder
- ☐ Diabetes
- ☐ Goiter
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other:_____

Gastrointestinal

- ☐ Chrohn's Disease
- ☐ Cholelithiasis
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Gastrointestinal Reflux
- ☐ GERD/Gastoesophageal Reflux
- ☐ GI Bleed
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ Ischemic Bowel
- ☐ Peptic Ulcer Disease
- ☐ Stomach Ulcers
- ☐ Other:_____

Infectious Disease

- ☐ CMV/Cytomegalovirus
- ☐ Endocarditis
- ☐ HIV/AIDS
- ☐ Lyme Disease
- ☐ MRSA/Methicillin Resistant Staph Aureus
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Sexually Transmitted Infection
- ☐ Tuberculosis/TB
- ☐ Other:_____

Musculoskeletal

- ☐ Carpal Tunnel
- ☐ DJD/Degenerative Joint Disease
- ☐ Fibromylagia
- ☐ Gout
- ☐ Herniated Disk
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Ruptured Disk
- ☐ Spinal Stenosis
- ☐ Other:_____

Physician Review:_____

Date:_____

CARDIAC & VASCULAR CENTER
OF NORTH TEXAS

MEDICAL HISTORY continued page 2

Initial Office Visit

Past Medical History: (Please place a check mark by any condition that you have now or have had in the past)

Dermatology
- ☐ Scleroderma
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Other:_____

Eyes, Ears, Nose, and Throat
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Other:_____

Renal/Genitourinary
- ☐ BPH/Benign Prostatic Hypertrophy
- ☐ Erectile Dysfunction
- ☐ Hematuria
- ☐ Kidney Stones
- ☐ Polycystic Kidneys
- ☐ Prostate Cancer
- ☐ Renal Insufficiency/Renal Failure

Hematology
- ☐ Anemia
- ☐ Coagulopathy
- ☐ Hemochromatosis
- ☐ Polycythemia Vera
- ☐ Other:_____

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema/COPD
- ☐ Lung Cancer
- ☐ Pneumonia
- ☐ Pulmonary Embolus
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea
- ☐ Tuberculosis/TB
- ☐ Other:_____
- ☐ Other:_____

OB/Gynecological
- ☐ Breast Cancer
- ☐ Benign Breast Lump
- ☐ Fibrocystic Breast Tissue
- ☐ Ovarian Cancer
- ☐ Ovarian Cyst
- ☐ Other:_____

Oncology
- ☐ Metastatic Cancer
- ☐ Bladder Cancer
- ☐ Other:_____

Rheumatologic
- ☐ Autoimmune Disease
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other:_____

Past Surgical History: (please place a check mark by any previous surgery/therapies and indicate the approximate date of each)

- ☐ Aneurysm Repair
- ☐ Angioplasty/PTCA
- ☐ Appendectomy
- ☐ Breast Augmentation
- ☐ Breast Biopsy
- ☐ Carotid Artery Endarterectomy
- ☐ Cataract Removal
- ☐ Cervical Fusion
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Coronary Artery Bypass
- ☐ Other
- ☐ Craniotomy
- ☐ Dialysis Access
- ☐ Diskectomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Inguinal Hernia Repair
- ☐ Kidney Stone Treatment
- ☐ Knee Surgery
- ☐ Laminectomy
- ☐ Mastectomy
- ☐ ORIF/Open Reduction Internal Fixation
- ☐ Prostatectomy
- ☐ Spleenectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Total Hip Replacement
- ☐ Total Knee Replacement
- ☐ Tubal Ligation
- ☐ TURP
- ☐ Vasectomy

_____

_____

_____

Physician Review:_____

Date:_____

CARDIAC & VASCULAR CENTER
OF NORTH TEXAS

MEDICAL HISTORY continued page 3

Initial Office Visit

Date of Service_____

Social History

What is your occupation?_____
What is you marital status?_____ Do you have children?_____ If yes, how many?_____
How many times per week to you perform a formal exercise routine?_____
What type of exercise program do you participate in? (please describe a typical exercise routine) _____
_____

Tobacco & Alcohol History

Do you smoke? ☐ Yes ☐ No
If no: Did you ever smoke? ☐ Yes ☐ No
How many years did you smoke?_____
What year did you quit?_____
How many packs per day did you smoke?_____
If yes: How many years have you been smoking?_____
How many packs per day do you smoke?_____
Do you drink alcohol? ☐ Yes ☐ No
If no: Did you ever drink alcohol? ☐ Yes ☐ No
How many drinks would you consume in an average week?_____
In what year did you stop consuming alcohol? _____
If yes: How many drinks do you consume in an average week? _____

Medications (please bring medication bottles with you to all visits)

Medication_____Dose_____Frequency_____
Medication_____Dose_____Frequency_____
Medication_____Dose_____Frequency_____
Medication_____Dose_____Frequency_____
Medication_____Dose_____Frequency_____
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Medication_____Dose_____Frequency_____
Medication_____Dose_____Frequency_____

Allergies

Are you allergic to iodine/ x-ray dye? ☐ Yes ☐ No
Are you allergic to shellfish? ☐ Yes ☐ No
Are you allergic to foods? ☐ Yes ☐ No List:_____
Are you allergic to medications? ☐ Yes ☐ No List:_____

Physician Review:_____
Date:_____

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MEDICAL HISTORY continued page 4

Initial Office Visit

Date of Service_____

Family History

Have any of your relatives been diagnosed with Coronary Artery Disease (heart attack, heart bypass surgery, angioplasty) or Peripheral Vascular Disease (history of stroke, TIAs or blocked arteries elsewhere in the body), and enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, aneurysm, sudden cardiac death, or Marfan's syndrome? Yes ☐ No

What type of heath conditions exist/existed in your...

Mother:_____

Father:_____

Siblings:_____

Maternal Grandparents:_____

PaternalGrandparents:_____

Aunts, Uncles, Cousins:_____

Review of Symptoms

Constitutional

☐ Yes ☐ No Unexplained weight gain
☐ Yes ☐ No Unexplained weight loss
☐ Yes ☐ No Fever or chills

ENT

☐ Yes ☐ No Vision changes
☐ Yes ☐ No Hearing changes
☐ Yes ☐ No Sore throat
☐ Yes ☐ No Ringing ears

Respiratory

☐ Yes ☐ No Cough
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Wheezing

Cardiac

☐ Yes ☐ No Awaken in the middle of the night from sound sleep because of difficulty breathing
☐ Yes ☐ No Chest discomfort with activity
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Fainting spells
☐ Yes ☐ No Irregular heartbeat
☐ Yes ☐ No Lightheadedness
☐ Yes ☐ No Neck discomfort with activity
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Require pillows to sleep on at nighttime or you'll become short of breath
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Swelling in your feet

Endocrine

☐ Yes ☐ No Excessive thirst
☐ Yes ☐ No Increased urination
☐ Yes ☐ No Extreme nervousness
☐ Yes ☐ No Heat or cold intolerance
☐ Yes ☐ No Unexplained weight loss

Neurological

☐ Yes ☐ No Loss of motor function
☐ Yes ☐ No Loss of sensory function
☐ Yes ☐ No Recurrent headaches
☐ Yes ☐ No Seizures
☐ Yes ☐ No Slurred speech
☐ Yes ☐ No Loss of balance

Psychological

☐ Yes ☐ No Anxiety
☐ Yes ☐ No Been under the care of a psychiatrist or psychologist
☐ Yes ☐ No Depression
☐ Yes ☐ No Hallucinations

Lymphatic

☐ Yes ☐ No Enlarged lymph nodes
☐ Yes ☐ No Unintentional weight loss

Muscular

☐ Yes ☐ No Bone or joint deformity
☐ Yes ☐ No Joint pains
☐ Yes ☐ No Lack of strength
☐ Yes ☐ No Muscle weakness or pain

Physician Review:_____

Date:_____

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MEDICAL HISTORY continued page 5

Initial Office Visit

Date of Service_____

Review of Symptoms

Gastrointestinal

☐ Yes ☐ No Abdominal tenderness
☐ Yes ☐ No Nausea or vomiting
☐ Yes ☐ No Blood in stool
☐ Yes ☐ No Constipation
☐ Yes ☐ No Dark tarry stool
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Vomiting of blood

Genitourinary

☐ Yes ☐ No Burning with urination
☐ Yes ☐ No Frequent urination
☐ Yes ☐ No Blood in urination
☐ Yes ☐ No Problems with urinary flow
☐ Yes ☐ No Dark urine

Men:

☐ Yes ☐ No Erectile dysfunction (difficulty obtaining or maintaining an erection)

Women:

☐ Yes ☐ No Been pregnant or delivered a baby within last year
Date of last menstrual period:_____
☐ Yes ☐ No Hysterectomy
☐ Yes ☐ No Is there any chance you could be pregnant?

Hematologic

☐ Yes ☐ No Anemia
☐ Yes ☐ No Excessive bleeding
☐ Yes ☐ No Taking a blood thinner
☐ Yes ☐ No List:_____
_____

Immunologic/Infections

☐ Yes ☐ No Fevers
☐ Yes ☐ No History of IV drug use
☐ Yes ☐ No Night sweats

Dermatologic

☐ Yes ☐ No Skin rashes
☐ Yes ☐ No Easy bruising
☐ Yes ☐ No Change in complexion

Physician Review:_____
Date:_____

CARDIAC & VASCULAR CENTER
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MEDICAL HISTORY continued page 6

Initial Office Visit

Date of Service_____

Physical Exam

HT:_____ WT:_____ HR:_____ BP(L):_____ BP (R):_____

	N=NORMAL A=ABNORMAL	EXPLAIN ABNORMAL FINDINGS
CONSTITU	General appearance_____	
EYE	Conjunctivae_____ Lids _____	
ENT	Oral Mucosa_____ Teeth/Gums/Palate_____	
NECK	Thyroid_____ Jugular_____	
RESP	Effort_____ AC _____	
HEART	Palp_____ Ausc_____ BP2+Ext_____ Carotid_____	
ABD	Masses/Tenderness_____ Liver _____ Spleen_____ Ausc _____	
MS	Back curve_____ Gait_____ Exer Tol_____ Strength Tone_____	
EXTREM	Clubbing/Cyanosis/Edema_____ Palp Digits/Nails_____	
SKIN	Describe scars, rashes, etc.	
NEURO/PSYC	Oriented_____ Mood_____ Affect_____	

Assessment:

_____

_____

_____

Plan:

_____

_____

_____

Physician Review:_____

Date:_____