PULSE- HEART | VALVE | VASCULAR
3420 Tamiami Trail, Unit 2
Port Charlotte, FL 33952
Telephone: (941) 629-2111
Fax: (941) 627-5377

Patient Name: _____ Date of Birth: _____ Date: _____

History of Present Illness

What is the reason for today's visit?

_____

_____

Past Medical History

Have you ever had the following?

Atrial Fibrillation	Yes	No	Heart Attack/Myocardial Infarction	Yes	No	Rheumatic Fever	Yes	No
Bleeding Problems	Yes	No	Heart Failure	Yes	No	Sleep Apnea	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Cardiomyopathy	Yes	No	Hiatal Hernia	Yes	No	Thyroid Disease	Yes	No
Carotid Artery Disease	Yes	No	Hypertension	Yes	No	Tuberculosis	Yes	No
Coronary Artery Disease	Yes	No	High Cholesterol	Yes	No	Whooping Cough	Yes	No
COPD	Yes	No	Kidney Disease	Yes	No			
Diabetes Mellitus	Yes	No	Peripheral Vascular Disease	Yes	No			
DVT	Yes	No						

Have you had any other medical problems that we have not asked about? _____

_____

Have you had any of the following?

Holter Monitor	Yes	No	Angioplasty or Stent	Yes	No	**Allergies:**		
Stress Test	Yes	No	CABG (Coronary Artery Bypass Surgery)	Yes	No			
Echocardiogram	Yes	No	Pacemaker Insertion	Yes	No			
Cardiac Catheterization	Yes	No	ICD (Defibrillator Insertion)	Yes	No			

Surgeries or Hospitalizations Not Listed Above

_____

_____

_____

Local Anesthetic	No	Yes
X-ray Dye or Iodine	No	Yes
Shellfish	No	Yes

Family History

Check All That Apply

Relationship	Living or Deceased	Diabetes	Hypertension	Heart Disease	Anemia	Arrhythmia	Asthma	Clotting Disorder	CVA (Stroke)	Heart Attack	Heart Failure	High Cholesterol
Mother												
Father												
Sister												
Brother												

Social History

Alcohol Use

Per Week

___ Glasses of Wine
___ Cans of Beer
___ Shots of Liquor
___ Drinks Containing 0.5 oz of Alcohol (Mixed Drinks)

Illegal Drug Use: _____ Currently _____ In the past

Caffeine Use **Yes** **No**

Cups per Day _____ Cups Per Day

Tobacco Use **Yes** **No** **Never**

Number of Years _____ Years Quit Date: _____ Packs per Day _____

Review of Systems

Have you experienced any of the following in the **past two months**?

Constitutional

Recent weight change . . . . . No Yes
Fever . . . . . No Yes
Fatigue . . . . . No Yes

Eyes

Eye disease or injury . . . . . No Yes
Blurred or double vision . . . . . No Yes
Glaucoma . . . . . No Yes
Cataracts . . . . . No Yes

ENT

Hearing loss . . . . . No Yes
Sinus pain . . . . . No Yes
Nose bleeds . . . . . No Yes

Cardiovascular

Chest pains . . . . . No Yes
Sudden heart beat changes/palpitations No Yes
Swelling of feet, ankles, or hands . . . . . No Yes

Respiratory

Frequent coughing . . . . . No Yes
Shortness of breath at rest . . . . . No Yes
Shortness of breath with activity . . . . . No Yes
Shortness of breath while lying flat . . . . No Yes
Asthma or wheezing . . . . . No Yes

Gastrointestinal

Loss of appetite . . . . . No Yes
Nausea or vomiting . . . . . No Yes
Frequent diarrhea . . . . . No Yes
Blood in stool . . . . . No Yes

Genitourinary

Frequent urination . . . . . No Yes
Burning or painful urination . . . . . No Yes
Blood in urine . . . . . No Yes
Kidney stones . . . . . No Yes

Joint pain . . . . . No Yes
Joint swelling . . . . . No Yes
Muscle pain or cramps . . . . . No Yes
Cold extremities . . . . . No Yes
Pain in legs when you walk . . . . . No Yes

Skin

Rash or itching . . . . . No Yes
Varicose Veins . . . . . No Yes

Neurological

Frequent or recurring headaches . . . No Yes
Light headed or dizzy . . . . . No Yes
Convulsions or seizures . . . . . No Yes
Numbness or tingling sensations . . . No Yes
Tremors . . . . . No Yes
Paralysis . . . . . No Yes
Fainting episodes . . . . . No Yes

Psychiatric

Memory loss or confusion . . . . . No Yes
Nervousness or anxiety . . . . . No Yes
Depression . . . . . No Yes

Endocrine

Excessive thirst or urination . . . . . No Yes
Heat or cold intolerance . . . . . No Yes

Hematologic/Lymphatic

Slow to heal after cuts . . . . . No Yes
Easily bruise or bleed . . . . . No Yes
Anemia . . . . . No Yes

Do you having any other medical concerns?

_____

_____

_____

_____