Advanced Cardiovascular Clinic

Medical History
Review of Systems Form

Date:_____ Name:_____ Date of Birth:_____

_____Married _____Single _____Divorced _____Widowed

Number of Children____ Tobacco Use: Yes/No/Quit How Much? ____/Day How Long/Year quit?____

Alcohol Use: How many drinks per day?____ Caffeine Per Day____

Past Illnesses (please check if yes)

□ Alcoholism	□ High Blood Pressure	□ Stroke	□Stents
□ Anemia	□ Kidney Disease	□ Suicide Attempt	□Other _____
□ Asthma	□ Liver Disease	□ Thyroid Disease	_____
□ Cancer/Tumor	□ Hepatitis	□ Tuberculosis. TB	_____
□ Diabetes	□ Lung Disease/COPD	□ Ulcer in GI Tract	
□ Drug Abuse	□ Mental Illness	□ High Cholesterol	
□ Depression	□ Osteoarthritis	□ HIV/Immune Dx	
□ Epilepsy	□ Osteoporosis	□ Congestive Heart Failure	
□ Glaucoma	□ Phlebitis	□ Bypass	
□ Heart Attack	□ Rheumatic Arthritis	□ Abnormal Heart Rhythm	

Past Surgical History (please include dates)

_____

_____

Review of Systems (please check if yes)

Constitutional:		**Endocrine:**		**Psychiatric:**	
Weight loss	□	Loss of Hair	□	Anxiety/Depression	□
Fatigue	□	Heat/Cold Intolerance	□	Mood Swings	□
Fever	□	**Respiratory:**		Difficulty Sleeping	□
Eyes:		Cough	□	**Hematology/Lymph**	
Glasses/Contacts	□	Wheezing	□	Easy Bruising	□
Eye Pain	□	Chills	□	Gums Bleed Easily	□
Double Vision	□	**Gastrointestinal:**		Enlarged Glands	□
Cataracts	□	Heartburn/Reflux	□	**Musculoskeletal:**	
Ear, Nose, Throat:		Nausea/Vomiting	□	Joint Pain/Swelling	□
Difficulty Hearing	□	Constipation	□	Stiffness	□
Ringing in Ears	□	Change in BMs	□	Muscle Pain	□
Vertigo	□	Diarrhea	□	Back Pain	□
Sinus Trouble	□	Jaundice	□	**Skin:**	
Nasal Stuffiness	□	Abdominal Pain	□	Rash/Sores	□
Frequent Sore Throat	□	Black/Bloody Stool	□	Lesions	□
Cardiovascular:		**Genitourinary:**		Itching/Burning	□
Murmur	□	Burning/Frequency	□	**Neurological:**	
Chest Pain	□	Blood in Urine	□	Loss of Strength	□
Palpitations	□	Erectile Dysfunction	□	Numbness	□
Dizziness	□	Abnormal Discharge	□	Headaches	□
Fainting Spells	□	Bladder Leakage	□	Tremors	□
Shortness of Breath	□	**Allergic/Immunologic:**		Memory Loss	□
Difficulty Lying Flat	□	Hives/Eczema	□		
Swelling Ankles	□	Hay Fever	□	**NONE**	□

Current Medications:

Name	Dosage (mg)	How Often (times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Health Care Providers in the Past Five Years:

Name	City/State	Reason	Still Seeing?
_____			Yes/No
_____			Yes/No
_____			Yes/No
_____			Yes/No

Allergies:

Are you allergic to latex? YES/NO
Are you allergic to seafood? YES/NO
Are you allergic to iodine? YES/NO
Are you allergic to dye? YES/NO
Do you have any medication allergies? YES/NO
If yes, please specify_____

Family History:

Are your parents alive? Mother: YES/NO Father: YES/NO
If deceased, please specify from what and when
Mother: _____ at age_____.
Father: _____ at age_____.
Do you have siblings with heart problems? YES/NO
If yes, please specify: _____
Do you have any family members with heart disease? YES/NO
If yes, please specify: _____

SIGNATURE_____