CARDIAC, THORACIC
& VASCULAR SURGERY
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Patient History Form

Date_____

Name: _____ **Birth date:** _____

Chief Complaint: What is the main reason for your visit today? _____

_____

History of Present Illness	
Location of Problem: Chest Arm Leg Abdomen Back Other:	Is there anything else occurring at the same time? Yes No Explain _____ Swelling Nausea Fever Chest Pain Other:
On a scale of 1-10, 10 being most severe, which number describes the problem: 1 2 3 4 5 6 7 8 9 10	Is the problem constant or variable? Dull then sharp Very sharp then leaves Constant Other:
How long have you experienced this complaint? _____	Does the problem interfere with your normal functions? Yes No Please Explain: _____
Does anything help or make the problem worse? Moving around Standing up Lying on Side Walking more than 2 blocks Other: _____	How long does the problem last? 30 minutes 1 hour It's always there Other: _____

Past Family Medical & Social History

	Past History	Family History		Past History	Family History
Heart Disease			History of Bleeding		
Kidney Disease			Seizures		
Stroke			Respiratory/Lung Disease		
Hypertension			Diabetes		
Cancer			Tuberculosis		

List any personal past illnesses and/or surgeries & when they occurred: _____

_____

Smoke: Yes No Number of Packs a day _____ How long have you smoked? _____
Are you a former smoker? Yes No Number of Packs a day ____ How long did you smoke? ____
Are you on a special diet Yes No If yes, explain: _____
Do you routinely exercise? Yes No How often? _____
Do you have any allergies? Yes No Please list _____

Name: _____

Are you taking any blood thinners? Yes No What kind? _____
If you are a diabetic, what medications are you taking? _____
Pharmacy Name: _____ Pharmacy Number: _____

Review of Systems

Constitution Symptoms:			**Integumentary**		
Fever	Yes	No	Skin Rash	Yes	No
Chills	Yes	No	Boils	Yes	No
Headache	Yes	No	Persistent Itch	Yes	No
Other			Other		
Eyes			**Musculoskeletal**		
Blurred Vision	Yes	No	Joint Pain	Yes	No
Double Vision	Yes	No	Neck Pain	Yes	No
Pain	Yes	No	Back Pain	Yes	No
Other			Other		
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**		
Hay Fever	Yes	No	Ear Infection	Yes	No
Drug Allergies	Yes	No	Sore Throat	Yes	No
List:			Sinus Problems	Yes	No
			Other		
Neurological			**Genitourinary**		
Tremors	Yes	No	Urinary Retention	Yes	No
Dizzy Spells	Yes	No	Painful Urination	Yes	No
Numbness	Yes	No	Urinary Frequency	Yes	No
Other			Other		
Gastrointestinal			**Respiratory**		
Abdominal Pain	Yes	No	Wheezing	Yes	No
Nausea/Vomiting	Yes	No	Frequent Cough	Yes	No
Heartburn	Yes	No	Shortness of Breath	Yes	No
Other			Other		
Cardiovascular			**Hemotalogic/Lymphatic**		
Chest Pain	Yes	No	Swollen glands	Yes	No
Varicose Veins	Yes	No	Blood Clotting	Yes	No
High Blood Pressure	Yes	No	Other		
Other					

Physician Reviewed: _____ Date: _____