OneHealth
A member of Owensboro Health

Cardiology
Pleasant Valley Center
1301 Pleasant Valley Road, Suite 202
Owensboro, KY 42303
Phone (270) 417-7500 • FAX (270) 417-7509

MR#_____

Patient Name _____ Date of Birth _____ Date _____

Medical Physician(s) _____

Who referred you or how did you hear about us? _____

History of Present Illness

What is the reason for today's visit? _____

Past Medical History

Have you ever had the following?

Arthritis	Yes	No	Dysrhythmia	Yes	No	Rheumatic Fever	Yes	No
Atrial Fibrillation	Yes	No	Heart Attack/Myocardial Infarction	Yes	No	Sleep Apnea	Yes	No
Bleeding Problems	Yes	No	Heart Failure	Yes	No	St Vitus Dance	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
COPD	Yes	No	High Cholesterol	Yes	No	Ulcers	Yes	No
Diabetes Mellitus	Yes	No	Kidney Disease	Yes	No	Whooping Cough	Yes	No
Diptheria	Yes	No	Pain in Legs When Walking	Yes	No			
DVT	Yes	No	PVD (Peripheral Vascular Disease)	Yes	No			

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

_____

_____

Have you had any of the following medical services?

Holter Monitor	Yes	No	Angioplasty or Stent	Yes	No
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

_____

_____

_____

Allergies:_____

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

Family History

Check All That Apply

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

Social History

Alcohol Use **Yes** **No**
Drinks/Week
___ ___ Glasses of Wine
___ ___ Cans of Beer
___ ___ Shots of Liquor
___ ___ Drinks Containing 0.5 oz of Alcohol

Comments _____
Alcohol/Week

Daily Caffeine Use **Yes** **No**
Cups/Day 1 2 3 4 5 _____per Day

Comments _____

Tobacco Use **Yes** **No** **Unknown**
Years 0.5 1 2 3 4 5 10 15 _____years

Packs/Day 0.25 0.5 1 1.5 2 3 _____ per Day
Quit Date _____

Smokeless Tobacco _____

Quit Date _____

Comment_____

Patient Social History

Marital Status: ____ Single ____ Married ____ Separated ____ Divorced ____ Widowed

Number of Children: _____ Occupation: _____

Review of Systems

Have you experienced any of the following in the past two months? Please answer all questions by circling yes or no.

Constitutional

Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes
Cataracts	No	Yes

ENT

Hearing loss	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Bleeding gums	No	Yes

Cardiovascular

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

Respiratory

Frequent coughing	No	Yes
Spitting up blood	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
Wake up at night smothering	No	Yes
Snore while sleeping	No	Yes
Excessive day time sleepiness	No	Yes
How many pillows do you sleep on?	_____	

Gastrointestinal

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes
Frequent indigestion	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney stones	No	Yes
Wake up at night to urinate	No	Yes

Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty walking	No	Yes
Pain in legs when you walk	No	Yes

Skin

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	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
Sleep problems	No	Yes

Endocrine

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

Are you having any other problems?

_____

_____

_____

_____

Patient signature: _____ Date of patient signature: _____

Provider signature: _____ Date of provider signature: _____