# UnityPoint Clinic - Cardiology

**Date Completed:** ________________________________ **Appointment Date:** __________________

**Name:** ________________________________________ **Age:** _______ **Birthdate:** __/__/___
FIRST MIDDLE INITIAL LAST

**Referred by:** ______________________________ **Family Dr.:** _________________________

**Reason for visit:**

______________________________________________________________________________

______________________________________________________________________________

**Describe briefly, include date of onset:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Doctors seen in past year:**

1. ________________________________________________
2. ________________________________________________
3. ________________________________________________

**Family History:**

| | Age | Serious Health Problems | Age at Death if deceased | Cause |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brother(s) | | | | |
| Sisters(s) | | | | |
| Children | | | | |
| Maternal Grandfather | | | | |
| Maternal Grandmother | | | | |
| Paternal Grandfather | | | | |
| Paternal Grandmother | | | | |

**Social History:**

Single ____ Married ______ Widowed _______ Divorced ________

Education: ______________________________________________

Last grade of school completed: ______________________________________________

Current/Prior Occupation: ______________________________________________

Do you smoke cigarettes? _____ no _____ yes - how much ________________ how long? ____________

Do you chew tobacco? _____ no _____ yes - how much ________________ how long? ____________

Do you drink alcohol? _____ no _____ yes - how much ________________ how long? ____________

Do you use illegal drugs? _____ no _____ yes - how much ________________ how long? ____________

Do you drink caffeine? _____ no _____ yes - how much ________________ how long? ____________

**Past Medical History:** Do you have or have you been treated for:

___ Alcoholism
___ Anemia
___ Anxiety
___Arrhythmias
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Bronchitis
___Cancer
___ Cataracts
___ Congestive Heart Failure
___ CPAP
___ Depression
___ Diabetes
___ Emphysema
___ Fainting
___ Glaucoma
___ Gout
___ Heart Attack
___ Heart Murmurs
___ Hepatitis
___ Hiatal Hernia
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Liver Disease
___ Migraine Headaches
___ Pneumonia
___ Polio
___ Rheumatic Fever
___ Scarlet Fever
___ Sleep Apnea
___ Stroke
___ Thyroid Problems
___ Tuberculosis
___ Ulcers
___ Other (please list) ______________________________________________

**Past History/Major Illnesses and Date (use reverse if needed)**

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________

**Hospitalizations (include surgeries):**

1. Where ________________________ When ________________ How Long ______
   Reason ______________________________________________
2. Where ________________________ When ________________ How Long ______
   Reason ______________________________________________
3. Where ________________________ When ________________ How Long ______
   Reason ______________________________________________

**Have you had the following tests done:**

___ Chest x-ray where ______________________________ When___________
___ EKG where ______________________________ When ___________
___ Echocardiogram where______________________________ When ___________
___ Treadmill where ______________________________ When ___________
___ Nuclear Stress Test where ______________________________ When ___________
___ Carotid Duplex where ______________________________ When ___________
___ Other Ultrasound where ______________________________ When ___________
___ Angiogram/Stents where ______________________________ When ___________
___ CAT Scan where ______________________________ When ___________

**Medications: PLEASE BRING ALL MEDICATIONS WITH YOU TO YOUR VISIT WITH THE DOCTOR**

| **Name of Drug** | **Dose (include strength and number of pills per day)** | **How long have you taken this medication?** |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |
| **6.** | | |
| **7.** | | |
| **8.** | | |
| **9.** | | |
| **10.** | | |
| **11.** | | |
| **12.** | | |

**Allergies (Please describe any reactions to medications):**

| |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |

**Review of Systems (check Yes if this applies to you):**

| **Musculoskeletal** | **Yes** | **Describe** |
|---|---|---|
| Pain or weakness: | | |
| Upper limbs | | |
| Lower Limbs | | |
| Joints | | |
| Falls | | |
| | | |
| **Neurology** | | |
| Memory difficulties | | |
| Headaches | | |
| Numbness/tingling | | |
| Balance difficulty | | |
| Seizures | | |
| Weakness | | |
| | | |
| **Genitourinary** | | |
| Frequent urination | | |
| Painful urination | | |
| Blood in urine | | |
| Difficulty starting urine stream | | |
| Sexual dysfunction | | |

| **Hematologic** | **Yes** | **Describe** |
|---|---|---|
| Easy bruising | | |
| Fever/chills | | |
| Sweats | | |
| | | |
| **Psychiatric** | | |
| Anxiety | | |
| Depression | | |
| | | |
| **Cardiovascular** | | |
| **Chest Pain: Please describe the approximate time pain began, the frequency, duration, what makes the pain start, and what makes the pain go away, in each box below.** | | |
| Sharp | | |
| Tightness | | |
| Heaviness | | |
| Pressure | | |
| At Rest | | |
| With Exertion | | |
| Right chest | | |
| Left Chest | | |
| Mid-chest | | |
| Whole Chest | | |
| Left/right arm pain | | |
| Nausea | | |
| Jaw Pain | | |
| Shortness of Breath | | |
| At rest | | |
| With exercise | | |
| Swelling of legs | | |
| Lightheadness | | |
| Blood clots | | |
| Pacemaker/defibrillator | | |
| | | |
| **Respiratory** | | |
| Cough | | |
| Difficulty breathing | | |
| Wheezing | | |
| Night Sweats | | |
| | | |
| **Gastrointestinal** | | |
| Appetite – poor/change | | |
| Constipation | | |
| Diarrhea | | |
| Abdominal Pain | | |
| Nausea/vomiting | | |
| Bloody or black stools | | |
| | | |
| **Constitutional** | | |
| Recent weight change | | |
| Change in energy level/fatigue | | |
| Difficulty falling asleep or staying asleep | | |
| Recurrent fevers/sweats | | |
| | | |

| **Eyes, Ears, Throat** | **Yes** | **Describe** |
|---|---|---|
| Double vision | | |
| Loss of vision | | |
| Blurred vision | | |
| Sore throat | | |
| Difficulty swallowing | | |
| Difficult speaking | | |
| Hearing change | | |
| Nosebleed | | |
| Sinus Problem | | |
| Bleeding of gums | | |
| | | |
| **Endocrine** | | |
| Excessive thirst | | |
| Hair loss | | |
| Pregnancy | | |
| Menopausal symptoms | | |
| Abnormal menstrual cycle | | |
| | | |
| **Skin** | | |
| Itching | | |
| Skin sores | | |
| Rashes | | |
| Discoloration | | |

Signature

Date