VIRGINIA HEART
Excellence in Cardiovascular Care

PATIENT HEALTH HISTORY FORM

Rev. 07/19

Thank you for your cooperation in providing us with a thorough history for your permanent file.
This will allow us to provide you with the best care possible.

1 Demographics

Full Name: F [ ] M [ ] L [ ] Date of Birth [/ /]

Primary Care Physician / Referring Provider: [ ]

Preferred Pharmacy Name	Phone	Location / Address

Alternate Pharmacy Name	Phone	Location / Address

2 Reason for Visit

Please explain reason for visit (symptoms, etc.): [ ]

3 Current Medications

Please list ***ALL*** medications you are currently taking; including over-the-counter supplements:

Medication Name	Strength	Frequency	Prescribing Doctor
If you need more room, continue list on reverse side of page.			

4 Allergies & Sensitivities

Please list ***ALL*** allergies and reactions:

Medication / Product Name	Reaction

☐ **NO KNOWN ALLERGIES**

5 Cardiac Risk Factors

YES	NO	Please check ***YES*** or ***NO*** for each cardiac risk factor that applies to **YOU**:
☐	☐	Have you ever used tobacco? If yes, how much for how long?: _____
☐	☐	Family history of heart disease? If yes, please explain in section **8** below.
☐	☐	High cholesterol or triglycerides?
☐	☐	High blood pressure?
☐	☐	Diabetes? If yes, what type? How long?: _____
☐	☐	Prior history of heart disease?
☐	☐	Overweight by more than 10 pounds?
☐	☐	Do you exercise? If yes, what kind and how often? _____
☐	☐	Have you reached menopause? If yes, Biological or Surgical?: _____

6 Past Medical / Cardiac Illness, Trauma and Surgical History

a. Please list all past **GENERAL medical illnesses**, diseases and conditions (include date/age of onset):

	Description of Illness	Date or Age of Onset		Description of Illness	Date or Age of Onset
1			5		
2			6		
3			7		
4			8		

b. Please describe any **HEART related problems** you have experienced (include date/age of onset):

	Description of Heart Problem	Date or Age of Onset		Description of Heart Problem	Date or Age of Onset
1			3		
2			4		

c. Please list all past **INFECTIOUS DISEASES** you had as an adult or child such as chicken pox, hepatitis, rheumatic fever, etc. (include date/age of onset):

	Description of Disease	Date or Age of Onset		Description of Disease	Date or Age of Onset
1			3		
2			4		

d. Please list all past **TRAUMA or INJURIES** you have received such as fractures, wounds, injuries from an auto accident, etc. (include date of occurrence):

	Description of Trauma/Injury	Date of Occurrence		Description of Trauma/Injury	Date of Occurrence
1			3		
2			4		

e. Please list all **SURGERIES and PROCEDURES** (knee surgery, tonsillectomy, appendectomy, etc.) you have had *EXCEPT HEART-RELATED* procedures. Please include date of surgery/procedure:

	Description of Surgery	Date		Description of Surgery	Date
1			3		
2			4		

6 Past Medical / Cardiac Illness, Trauma and Surgical History (cont.)

f. Please list all surgeries and procedures you have had for your **HEART** (including stress test(s), echocardiogram(s), catheterization(s), bypass, etc.) Please include date of surgery/procedure:

	Description of Cardiac Procedure	Date		Description of Cardiac Procedure	Date
1			4		
2			5		
3			6		

7 Lifestyle / Social History

Y / N Please mark yes or no; and/or circle and complete as applicable:

- ☐ **Alcohol Use:** ☐ beer ☐ wine ☐ mixed drinks (check all that apply) How much / How often?:
- ☐ **Current Smoking/Tobacco Use:** ☐ cigarettes ☐ cigars ☐ pipe ☐ smokeless (check all that apply) Frequency:
  Have you used tobacco in the past? ☐ Yes ☐ No If Yes, for how long and when did you quit:
- ☐ **Diet:** ☐ regular ☐ weight reduction ☐ heart healthy ☐ low sodium ☐ low fat ☐ diabetic ☐ vegetarian ☐ other:
- ☐ **Caffeine Intake:** What kind/How much per day?:
- ☐ **Exercise:** ☐ None ☐ Occasional ☐ Regular ☐ Daily (check one) What type/How long?:
- ☐ **Drug/Substance Abuse:** Explain:

8 Family History

Please describe all family health problems (list condition, and age of onset):

Mother:	**Father:**
Grandfather:	Grandfather:
Grandmother:	Grandmother:
Siblings:	Other: OR: ☐ Unknown ☐ None

9 General Review of Systems

Please check ***ALL*** that apply to **YOU**:

General/Constitutional
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Decreased exercise tolerance
- ☐ Fatigue
- ☐ Loss of appetite

Integumentary
- ☐ Hair loss

Eyes
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wear ☐ glasses ☐ contacts

Ears / Nose / Mouth / Throat
- ☐ Hearing loss ☐ partial ☐ complete
- ☐ Difficulty speaking

Respiratory
- ☐ Cough
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exercise
- ☐ Sleep apnea

Cardiovascular
- ☐ Chest discomfort; if yes, describe:
- ☐ Palpitations
- ☐ Swelling of ankles/feet

Musculoskeletal
- ☐ Arthritis; list type: ☐ Loss of strength

Gastrointestinal
- ☐ Nausea
- ☐ Blood in stool
- ☐ Stomach ulcers

Neurological
- ☐ Previous stroke
- ☐ Confusion
- ☐ Dizziness
- ☐ Headaches
- ☐ Seizures

Endocrine
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Psychiatric
- ☐ Anxiety ☐ Stress ☐ Depression
- ☐ History of drug abuse
- ☐ History of alcohol abuse

Hematological/ Immunologic
- ☐ Bleeding disorder
- ☐ Seasonal allergies ☐ Food allergies

Peripheral Vascular
- ☐ Decreased walking endurance
- ☐ Foot Pain or Numbness
- ☐ Painful cramping or sharp pains of the legs or hips with physical activity
- ☐ Foot or toe wounds that are slow to heal

Please let the clinician know if there is something not listed, or write other issues with these systems on reverse side of page.