Southern Cardiovascular Care, PC

1800 Fairview Avenue, Suite 1
Dothan, AL 36301
Phone: 334 699-8900
Fax: 334 699-7498

HISTORY FORM

Patient Name:_____Date of Birth:_____

Appointment Date/Time_____ Referring Physician:_____

Reason for Referral:_____

PLEASE READ ALL OF THE INFORMASTION BELOW AND FILL IN ALL BLANKS WITH AS MUCH INFORMATION AS POSSIBLE,(DATES,AGES,ETC).

Cardiac Risk Factors: (Please check YES or NO)

Have YOU The Patient Ever had any of the following:

High Blood Pressure?	☐YES	☐ NO	When?
Diabetes?	☐ YES	☐ NO	When?
High cholesterol?	☐ YES	☐ NO	When?
Stroke/TIA?	☐ YES	☐ NO	When?
Neck Artery Blockage?	☐ YES	☐ NO	When?
Leg. Artery Blockage?	☐ YES	☐ NO	When?
Family History of Heart Disease?	☐ YES	☐ NO	Who?

Use TOBACCO? ( )YES ( )NO, I quit ( ) NO / Never

What type? ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Dip ☐ Chew ☐ Other Types

How much per day?_____ How many years? _____When did you quit?_____

FEMALES ONLY:

Completed/going through Menopause? ☐ YES ☐ NO When?_____

Partial OR Complete Hysterectomy? ☐ YES ☐ NO When?_____

Hormone Replacement Therapy? ☐ YES ☐ NO What?_____

Cardiac History: (Please check YES or NO and give details; when, where, etc.)

Have YOU The Patient had any of the following :

ECG (electrocardiogram)? ☒ YES ☐ NO _____

Known Rhythm Problems? ☐ YES ☐ NO _____

Holter Monitor (24 hours or 30 Days)? ☐ YES ☐ NO _____

Echocardiogram (Ultrasound of Heart?) ☐ YES ☐ NO _____

carotid Ultra Sound ? ☐ YES ☐ NO_____

Stress Testing (Nuclear or Regular)? ☐ YES ☐ NO _____

Heart Catheterization? ☐ YES ☐ NO _____

Angioplasty (Balloon)/ Stent Placement? ☐ YES ☐ NO _____

_____

Heart Surgeries (Bypass / Valve Replacement / Pacemaker / AICD Implant)? ☐ YES ☐ NO
Heart Attack? ☐ YES ☐ NO _____

Please Bring all medications and insurance cards. Please be prepared to pay your co-pay.

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MEDICAL HISTORY : (Please circle any problem that YOU , the patient may have/had)

Anemia Asthma Bladder Problems Bleeding Diathesis Cancer Carpal Tunnel Syndrome
Colon Polyps DVT(blood clot in leg) Fibromyalgias Gallbladder Problems
Gastroesophageal Reflux Gastrointestinal Disease Glaucoma Gout Liver Problems
Kidney Stones Obstructive Sleep Apnea / CPAP Osteoarthritis Other: _____
Psychiatric Disorder Lung Problems PTE(blood clot in lungs) Kidney Problems
Rheumatic Fever Rheumatoid Arthritis Scarlet Fever Scoliosis Thyroid Disease
Tuberculosis **NONE**

SURGICAL HISTORY/HOSPITALIZATIONS: (Please include approximate dates)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: (Please check YES or NO and What type of reactions did you have?)

Shellfish ☐ YES ☐ NO _____
Iodine ☐ YES ☐ NO _____
IVP Dye ☐ YES ☐ NO _____
Latex ☐ YES ☐ NO _____
Food ☐ YES ☐ NO _____
Drugs ☐ YES ☐ NO _____

Current Medications:

Please include all Insulin, over the counter medications/vitamins/herbs and their strengths and how often you take each of them.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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Family History: (Please fill out all areas COMPLETELY)

Relative	Age(s)	Health Status	Explanation
Father		() Living/Well () Living/minor problems ()Living/major problems ()Deceased	
Mother		() Living/Well () Living/minor problems ()Living/major problems ()Deceased	
Brother(s)		() Living/Well () Living/minor problems ()Living/major problems ()Deceased	
Sister(s)		() Living/Well () Living/minor problems ()Living/major problems ()Deceased	
Children Please note by age if male or female child.	_____ _____	() Living/Well () Living/minor problems ()Living/major problems ()Deceased () Living/Well () Living/minor problems ()Living/major problems ()Deceased () Living/Well () Living/minor problems ()Living/major problems ()Deceased	

Social History: (Please check all that apply)
Are YOU, the patient

( ) Married ( ) Single ( ) Widowed ( ) Divorced ( ) Separated
( ) live alone ( ) live with Family / Friend / Other - Number of People in house is _____
( ) In School - Where? _____
( ) Working - Where & type? _____ How long?_____
( ) Retired - From? _____ How long?_____
( ) Disabled - Why? _____ How long?_____

Do YOU, the patient:
Use ILLEGAL DRUGS? ( ) YES ( ) NO, I quit ( ) NO / Never
What type?_____
How often? ( ) Daily ( ) Weekly ( ) Monthly ( ) Socially ( ) Rarely
How many years? _____ When did you quit?_____
Use ALCOHOL? ( ) YES ( ) NO, I quit ( ) NO / Never
What type? ( ) Beer ( ) Wine ( ) Whiskey ( ) ALL Types
How often? ( ) Daily ( ) Weekly ( ) Monthly ( ) Socially ( ) Rarely
How many years? _____ When did you quit?_____
Intake CAFFEINE? ( ) YES ( ) NO, I quit ( )NO/Never
TYPE: ( ) Coffee - how much? _____ ( ) Tea - how much? _____
( ) Soda - how much? _____ ( ) Chocolate - how much? _____
( ) Other - how much? _____

ADVANCED DIRECTIVE:
Living Will ( ) YES ( ) NO
Organ Donor ( ) YES ( ) NO

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Symptoms:
Please circle ALL that apply OR check None of the above.
Constitutional: Fatigue, fever, chills, weight change, headaches, loss of appetite, night sweats, abnormal activity level. NONE
Head, Eyes, Ears, Nose, Mouth, Throat: Head pain, dizziness, dry eyes, conjunctivitis, cataracts, double vision, blurred vision, glasses, vision loss, hearing loss, ear pain, ringing in ears, sinusitis, nasal obstruction/discharge, nose bleeds, ear drainage, snoring, sore throat or mouth sores, hoarseness, trouble swallowing, tooth/gum trouble, dry mouth, wears dentures, swollen lymph nodes. NONE
Cardiovascular: Chest pain, shortness of breath, shortness of breath when lying down, edema, palpitations, murmurs, passing out, nearly passing out, high blood pressure, cyanosis. NONE
Respiratory: Asthma, coughing, wheezing, coughing up sputum, night-time shortness of breath, fast breathing, coughing up blood. NONE
Gastrointestinal: Nausea, vomiting, diarrhea, constipation, laxative use, hemorrhoids, bloody stool, abdominal pain, food intolerance, abnormal stool, change in bowel habits, vomiting blood, jaundice or Hepatitis;, black stool, use of antacids, anorexia. NONE
Musculoskeletal: Back pain, muscle weakness, stiffness, neck pain, muscle pain, cramps, Loss of motion, joint pain/swelling/inflammation. NONE
Neurological: Paralysis or weakness, numbness, seizure activity, tremors, dizziness, head trauma, syncope vertigo, headache, local weakness, tingling, memory loss, neuropathy. NONE
Integumentary: Acne, birth marks, body piercing, dryness, eczema, overgrowth of hair, itching, loss of hair, lumps, nail biting, scalp flaking and itching, skin rashes, skin cancer, tattoos, scars. NONE
Psychiatric: Anxiety, depression, suicidal thoughts or attempts. NONE
Endocrine: Diabetes, goiter or thyroid disease, excessive urination, sleep disturbance, weight gain or loss, excessive thirst, heat or cold intolerance, excessive swallowing, excessive sweating. NONE
Hematologic/Lymphatic: Abnormal bleeding, anemia, bruising, swelling of lymph gland, nose bleeds, past transfusions. NONE
Female Genitourinary: Abnormal menses, vaginal discharge, change in sexual activity, pregnancy, blood in the urine, Chlamydia, frequency, painful urination, intermenstrual bleeding, vaginal itching, Condyloma, Herpes, Gonorrhea, painful menstrual cycle, pelvic pain, excessive urination, dribbling.
NONE
Male Genitourinary: Change in sexual activity, blood in the urine, frequency, painful urination, Condyloma, Herpes, Gonorrhea, excessive urination, dribbling. NONE

I certify that this information is true and complete to the best of my knowledge.

_____	_____	_____
Patient's Signature	Preparer's Signature	Date

_____	_____
Southern Cardiovascular Care Personnel	Date

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