

Green Mountain **CARDIOLOGY**

Your trusted choice for advanced, comprehensive care

PATIENT'S PERSONAL HISTORY

Patient No. _____

Date _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name		First	Middle	Birth Date	Age	Birth Place	
Address		City	State	Zip	Home Phone		Business Phone
Occupation	Medicare No.		Medicaid No.		Sex M F	Marital Status	Soc. Sec. #
Insurance Company			Insurance No.				

Person to Notify _____ Relationship _____

Address _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

Address _____

FAMILY HISTORY	Sex		If Living		If Deceased	
			Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters* (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/Wife						

**Since some names may be used for either men or women, please circle sex for each Brother or Sister.*

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke _____	Epilepsy _____	Stomach ulcers _____
Cancer _____	Migraine _____	Kidney disease _____
High blood pressure _____	Asthma _____	Arthritis _____
Tuberculosis _____	Bleeding tendency _____	Rheumatic heart _____
Diabetes _____	Heart attack _____	Congenital heart _____

PERSONAL HABITS: (Circle)

Yes No Have you ever smoked? When did you stop? _____

Yes No Do you regularly drink alcohol? 1 oz. per day 2 oz. per day 4 oz. per day

BEER: 1 bottle per day 2 bottles per day over 4 bottles per day

To be answered by WOMEN only:

Date of last menstrual period _____

To be answered by MEN and WOMEN: (Circle)

Yes No Have you had changes in your weight?

Yes No Do you have any fever or chills?

Yes No Have you had a loss of vision?

Yes No Loss of hearing?

Yes No Sore throat?

Yes No Hoarseness?

Yes No Have you ever fainted?

Yes No Spells of dizziness?

Yes No Spells of weakness of an arm or leg?

Yes No Have you ever had a convulsion?

Have you ever had shortness of breath?: (Circle)

Yes No Doing your usual work?

Yes No Climbing a flight of stairs?

Yes No Which awakens you at night?

Yes No Do you have periods of apnea?

Yes No Do you snore?

Yes No Have you ever coughed blood?

Yes No Do you cough up much sputum?

Have you ever had chest pain or tightness in the chest which: (Circle)

Yes No Begins when exerting yourself?

Yes No Begins when walking up a hill?

Yes No Begins after a heavy meal?

Yes No Begins when upset or excited?

Yes No Have you had palpitations?

Yes No Radiates down the arm?

Yes No Disappears if you rest?

Yes No Occurs only at rest?

Yes No Begins when walking fast?

Yes No Begins when walking in cold weather?

Yes No Do you sleep on more than one pillow?

If you have chest pain or tightness, please explain _____

Have you recently had: (Circle)

Yes No Pains in calves of legs when walking?

Yes No Do you have joint aches?

Yes No Do you have joint swelling?

Yes No Varicose veins?

Yes No Phlebitis or inflamed leg veins?

Yes No Swelling in ankles?

Yes No Do you have muscle aching?

Yes No Do you urinate frequently at night?

Yes No Do you have burning with urination?

Yes No Blood in urine?

Do you have: (Circle)

Yes No Anemia?

Yes No Bruising?

Yes No Bleeding?

Yes No Diabetes?

Yes No Thyroid Disease?

Yes No Do you have any skin rashes?

Yes No Blood in stool?

Yes No Anxiety?

Yes No Depression?

Yes No Nausea and Vomiting?

Yes No Heartburn?

Yes No Constipation or diarrhea?

Yes No Difficulty with swallowing?

