MEDICAL HISTORY

MyCardiologist
Heart Specialists of Orange County

Name: _____ Age: _____ Date: _____

Reason for Visit or Chief Complaint: _____

_____

Referred By: _____

I. Have you had any reactions, allergies or bad effects from any of the following:

None ☐

If yes, please mark

Serum	☐	Aspirin	☐
Penicillin	☐	Morphine	☐
Other Antibiotics	☐	Other drugs, specify: _____	
Codeine	☐	_____	
Sulfa Drugs	☐	_____	

II. Have you ever had any of the following:

If yes, please check.

1. Rheumatic Fever	☐	7. Heart Attack	☐
2. Glaucoma	☐	8. Other Heart Disease	☐
3. Migraine Headaches	☐	9. Tuberculosis, Asthma or Emphysema	☐
4. Stroke or Paralysis	☐	10. Ulcer or Colon Problems	☐
5. Cancer or Tumor	☐	11. Kidney or Bladder proArthritis or Gout	☐
6. Fits or Epilepsy	☐	12. Anemia	☐

Have you had illnesses other than those listed above? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

III.

Relation	Age if living	If deceased—cause of death	Age at death
Father			
Mother			
Brothers			
Sisters			
Children Male			
Children Female			

IV. Operation: Have you had any surgical treatment or operations? If yes, list below.

V. Have you had any serious accidents or injuries? If yes, list below.

VII. Habits

1. Do you now or have you ever smoked? Please check what applies. ☐ Yes ☐ No

   If yes, ☐ Cigars ☐ Cigarettes ☐ Pipe ☐ Other

2. If yes, how much? _____ How long? _____ If you have stopped, how long ago? _____
3. Do you follow a regular exercise program? _____
4. Do you drink alcoholic beverages? Please check what applies.

   ☐ Never ☐ Occasionally ☐ Almost daily ☐ More than above

5. Do you drink coffee, tea or other caffeinated beverages? Check one. ☐ Yes ☐ No

   If yes, ☐ Less than 5 cups per day ☐ More than 5 cups per day

6. Are you on any special diet? Please specify. _____

VIII. Risk Factors

	Yes	No	Don't Know
1. Do you have high cholesterol?	☐	☐	☐
2. Do you have high blood pressure?	☐	☐	☐
3. Do you have sugar diabetes?	☐	☐	☐
4. Do you have gout or a high uric acid?	☐	☐	☐
5. Are you sedentary? (Exercise less than 3 times per week for at least 20 minutes)	☐	☐	☐
6. Have you ever had discomfort in the chest, neck, shoulders, arms, jaw or throat during exercise or stress?	☐	☐	☐
7. Do you get short of breath easily during everyday activities?	☐	☐	☐
8. Do you get cramps in your calves or thighs when walking or climbing stairs?	☐	☐	☐
9. Have you ever had a temporary loss of vision in one eye?	☐	☐	☐

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IX. Have you ever had or do you now have any of the following? If Yes, please check.

- ☐ Dizziness or Blackouts
- ☐ Goiter or Thyroid trouble
- ☐ Pain or difficulty swallowing
- ☐ Frequent hoarseness
- ☐ Chronic cough
- ☐ Coughed up blood
- ☐ Severe or recurrent pain in chest
- ☐ Pneumonia or Pleurisy
- ☐ Heart murmur
- ☐ Shortness of breath climbing stairs
- ☐ Swelling of ankles
- ☐ Irregular palpitations or Fast heart beat
- ☐ Pain or Cramps in legs with walking
- ☐ Varicose veins or Phlebitis
- ☐ Recent change in appetite
- ☐ Change in weight
- ☐ Vomiting of blood
- ☐ Frequent vomiting
- ☐ Recurrent burning in stomach
- ☐ Frequent diarrhea or constipation
- ☐ Pain after drinking alcoholic beverages
- ☐ Ulcer of legs or feet
- ☐ Chronic abdominal pain
- ☐ Frequent belching or bloating
- ☐ Hemorrhoids
- ☐ Red blood or Black tarry stools
- ☐ Excessive thirst
- ☐ Alcoholism
- ☐ Narcotic or drug habit
- ☐ Attempted suicide
- ☐ Frequent depression
- ☐ Prostate problems
- ☐ Disabling back pain
- ☐ Blood disorder
- ☐ Chronic skin condition
- ☐ Hives