South Texas Cardiovascular Consultants | New Patient History

Name:_____ STCC Cardiologist Name: _____

Date of Birth:_____/_____/_____ Referring Physician Name: _____

MEDICATION ALLERGIES: List any medications you are allergic to, include the reaction you experience: If none, Please write NKDA (No Known Drug Allergies):

_____

_____

List ALL medications you are CURRENTLY taking. (Include all vitamins & herbal/mineral supplements.)

Medication name & dosage	Taken how often?	Who prescribed?	Medication name & dosage	Taken how often?	Who prescribed?
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		

CHIEF COMPLAINT: Reason you are seeing a cardiologist today

_____

_____

CARDIAC RISK FACTORS: Please circle Yes or No for the following questions:

Do you use tobacco? Yes ☐ or ☐ No
Do you have high cholesterol? Yes ☐ or ☐ No
Do you have high blood pressure? Yes ☐ or ☐ No

Does your **family** have a history of heart disease?
*Family includes parents & siblings Yes ☐ or ☐ No
Do you have diabetes? Yes ☐ or ☐ No

Past Medical Illness: Mark any condition that you have, even if the condition is controlled with medication.

☐	HIGH BLOOD PRESSURE	☐	PERIPHERAL VASCULAR DISEASE	☐	SLEEP APNEA
☐	LOW BLOOD PRESSURE	☐	DIZZINESS	☐	CANCER
☐	SHORTNESS OF BREATH	☐	THYROID DISEASE	☐	GALL BLADDER DISEASE
☐	CAROTID ARTERY DISEASE	☐	DEPRESSION/ ANXIETY/ STRESS	☐	ACID REFLUX
☐	STROKE (TIA) OR (CVA)	☐	LUPUS	☐	STOMACH ULCER
☐	PASSING OUT EPISODES	☐	MIGRAINE HEADACHES	☐	THYROID PROBLEMS
☐	ELEVATED CHOLESTEROL	☐	FIBROMYALGIA	☐	ARTHRITIS

Past Cardiac Illness: Mark any conditions you have had, or mark no previous cardiac disease.

☐	NO PREVIOUS CARDIAC DISEASE	☐	VENTRICULAR TACHYCARDIA	☐	AORTIC ANEURYSM
☐	CHEST PAIN	☐	PALPITATIONS	☐	AORTIC STENOSIS
☐	ANGINA	☐	ARRHYTHMIA	☐	HEART MURMUR
☐	ABNORMAL EKG	☐	ATRIAL FIBRILLATION	☐	PERICARDITIS

	CORONARY ARTERY DISEASE		ATRIAL FLUTTER		PULMONARY EDEMA
	CONGESTIVE HEART FAILURE		SICK SINUS SYNDROME		MI (HEART ATTACK)
	CARDIOMYOPATHY		MITRAL VALVE PROLAPSE		MITRAL STENOSIS

INFECTIOUS DISEASE HISTORY: Please write the date or year if you were diagnosed with any of the following:

	DATE		DATE
HEPATITIS A:		HIV/AIDS:	
HEPATITIS B:		SWINE FLU:	
HEPATITIS C:		FLU:	
TUBERCULOSIS:		SHINGLES:	
MENINGITIS:		MALARIA:	
RHEUMATIC FEVER:		SCARLET FEVER:	

Other:

TRAUMA: LIST ANY, RECENT ACCIDENTS OR INJURIES. (Ex. burns, fractures etc…)

1. _____ Date/Yr: _____
2. _____ Date/Yr: _____
3. _____ Date/Yr: _____
4. _____ Date/Yr: _____

LIST ANY SURGICAL PROCEDURES.

1. Hospitalized for: _____ Date/Yr: _____
2. Hospitalized for: _____ Date/Yr: _____
3. Hospitalized for: _____ Date/Yr: _____
4. Hospitalized for: _____ Date/Yr: _____

SOCIAL HISTORY:

Alcoholic Beverages: Specify, what type, how much, and how often?

_____

Tobacco: Specify what type, how much, and how long?

_____

Caffeine Intake:

_____

Diet: Specify type, and for how long?

_____

Exercise: Specify what type, how often, and for how long?

_____

Substance abuse: Specify what type, how much, and for how long?

_____

FAMILY MEDICAL HISTORY: *We are **not** asking for your family member's name. Please **only** include AGE of family member if they are deceased. * If family member is still living do not write down their age. (Example: brother: heart attack, stroke, diabetes, high cholesterol, high blood pressure. Age at death 54)

MOTHER:_____ Age at death _____
FATHER:_____ Age at death _____
BROTHER:_____ Age at death _____
SISTER:_____ Age at death _____
PATERNAL GRANDMOTHER:_____ Age at death _____
PATERNAL GRANDFATHER:_____ Age at death _____
MATERNAL GRANDMOTHER:_____ Age at death _____
MATERNAL GRANDFATHER:_____ Age at death _____

REVIEW OF SYSTEMS: Please mark any of the following that **currently** apply to you.

	GENERAL		**INTEGUMENTARY (SKIN)**		**EYES**
	FATIGUE		ITCHING		SPOTS
	DECREASED EXERCISE TOLERANCE		RASH		TRANSIENT VISION LOSS
	WEIGHT LOSS		SORES/ULCERS DO NOT HEAL		GLAUCOMA
	WEIGHT GAIN		MOLE/NODULE CHANGES		CATARACTS
	Change in appetite: (**Circle one**) Increase or Decrease		ABNORMAL HAIR LOSS		MACULAR DEGENERATION
	RECURRENT FEVER/CHILLS		NAILS SPLITTING BREAKING OFF		BLURRED VISION
	NIGHT SWEATS		HIVES		DETACHED RETINA
	EARS, NOSE, MOUTH, THROAT		**RESPIRATORY**		**CARDIOVASCULAR**
	SEASONAL SINUSITIS		PERSISTANT COUGH		CHEST PAIN AT REST
	HOARSENESS / DIFFICULTY SPEAKING		SHORTNESS OF BREATH WHILE LYING FLAT		CHEST PAIN WITH ACTIVITY
	DIFFICULTY HEARING		WHEEZING		CHEST PRESSURE
	BUZZING AND RINGING EARS		ASTHMA		CHEST TIGHTNESS
	TOOTHACHES		ALLERGIES		NAUSEA/ W CHEST PAIN
	INNER EAR INFECTIONS		SPUTUM		RADIATING CHEST PAIN
	HEARING AIDS		SHORTNESS OF BREATH WITH EXERTION		PAIN BETWEEN SHOULDER BLADES
	CONGESTION		SHORTNESS OF BREATH WHILE AT REST		PAIN RADIATING UP NECK AND JAW
	SNORING		PALPITATIONS		HISTORY OF ASTHMA
	LEFT ARM NUMBNESS / TINGLING		HISTORY OF COPD		PASSING OUT EPISODES
	FREQUENT NAPPING		SWELLING FEET/ANKLES		
	GASTROINTESTINAL		**GENITOURINARY**		**MUSCULAR/VASCULAR**
	GERD		INCREASE IN FREQUENCY		JOINT PAIN AND STIFFNESS
	INDIGESTION		PAINFUL URINATION		JOINT SWELLING
	VOMITING		INCONTINENCE		LEG PAIN WHILE WALKING
	DIARRHEA		SMALL/STREAM		BLOOD CLOTS/ PHLEBITIS
	CONSTIPATION		DRIBBLING		HAIR LOSS ON LEGS, FEET, TOES
	DIVERTICULITIS		BLOOD IN URINE		NUMBNESS/TINGLING LEGS, FEET AND TOES
	BLEEDING ULCERS		BLADDER INFECTION		CONSTANT LEG PAIN

NEUROLOGICAL		PSYCHOLOGICAL		ENDOCRINE	
	MEMORY LOSS/CONFUSION		MENTAL ILLNESS		DIABETES
	DIZZINESS/LIGHTHEADED		DEPRESSION AND SADNESS		HYPOTHYROIDISM
	VERTIGO		ANXIETY		HYPERTHYRIODISM
	SEIZURES		STRESS		HEAT INTOLERANCE
	MIGRAINES/HEADACHES		DIFFICULTY SLEEPING		COLD INTOLERANCE
	GAIT PROBLEMS		EATING DISORDER		KIDNEY PROBLEMS
	TIA SYMPTOMS		CHANGE OF MOOD		CHANGE IN SEX DRIVE
HEMATOLOGICAL/(BLOOD SYSTEM)					
	BLEEDING DISORDER		EASY BRUISING		CHRONIC ANEMIA

Patient initials:_____ **Date of birth:**_____/_____/_____