



Denton Cardiology

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Name: _____ D.O.B. ____/____/____ Age: _____

MEDICATIONS (Please list all medications, dose, and frequency)

CURRENT MEDICATIONS: _____

Drug Allergies: _____

MEDICAL HISTORY

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Swelling | <input type="checkbox"/> Prior Bypass (Year) _____ |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Prior Stent (Year) _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Other Heart Surgery _____ |
| <input type="checkbox"/> Thyroid Problem | | | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

FAMILY MEDICAL HISTORY

- | | | | | | | | | | | | | | | |
|---------------------------------------|--------|--------|--------|---------|--|--------|--------|--------|---------|---------------------------------------|--------|--------|--------|---------|
| <input type="checkbox"/> CAD | Mother | Father | Sister | Brother | <input type="checkbox"/> Hypertension | Mother | Father | Sister | Brother | <input type="checkbox"/> Stroke | Mother | Father | Sister | Brother |
| <input type="checkbox"/> Lung Disease | M | F | S | B | <input type="checkbox"/> Liver Disease | M | F | S | B | <input type="checkbox"/> Cancer | M | F | S | B |
| <input type="checkbox"/> Tuberculosis | M | F | S | B | <input type="checkbox"/> Diabetes | M | F | S | B | <input type="checkbox"/> Other: _____ | | | | |

SOCIAL HISTORY

- | | | | |
|---|-----|----|--------------------------------------|
| Do you currently smoke? | Yes | No | If yes how much? _____ |
| Have you ever smoked? | Yes | No | If yes how long ? _____ |
| | | | When did you quit? _____ |
| Do you consume alcohol? | Yes | No | If yes how much? _____ |
| Have you gained/lost weight in the last 3 months? | Yes | No | If yes how much? _____ |
| Do you or have you used drugs? | Yes | No | If yes what time and how long? _____ |

REVIEW OF SYMPTOMS

- | | | | | |
|--|--|--|---|--|
| GENERAL: | RESPIRATORY: | M/S-NUERO: | VISION: | ENDOCRINE: |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Head Colds | <input type="checkbox"/> Extreme backache | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Excessive Thirstiness |
| <input type="checkbox"/> Itchy Skin | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Glasses | <input type="checkbox"/> Hungry after meals |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pain or Numbness | <input type="checkbox"/> Double Vision | |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Glaucoma | |
| <input type="checkbox"/> Changes in hair | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Cramps | <input type="checkbox"/> Cataracts | |
| <input type="checkbox"/> Constant Fatigue | <input type="checkbox"/> Nasal Blockage | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Floaters in Eye | |
| <input type="checkbox"/> Changes in Mood | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Severe Headaches | | |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Coordination Problems | | |
| <input type="checkbox"/> Changes in Skin | <input type="checkbox"/> Bloody Sputum | <input type="checkbox"/> Dizziness | | |
| CARDIOVASCULAR: | | | WOMEN: | |
| <input type="checkbox"/> Chest Pain | | | Do you still have menstrual periods? Yes No | |
| <input type="checkbox"/> Leg/Ankle Swelling | | | Last Period: _____ | |
| <input type="checkbox"/> Fast/Slow Heart Beat | | | Last Pap Smear: _____ | |
| <input type="checkbox"/> Shortness of Breath with Activity | | | | |
| <input type="checkbox"/> Shortness of Breath while laying down | | | | |
| <input type="checkbox"/> Shortness of Breath with sleeping | | | | |