Denton Cardiology

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Name: _____ **D.O.B.** ___/___/____ **Age:** _____
Social Security #: _____-_____-_____

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

CURRENT MEDICATIONS (Including **ALL** over the counter medications/supplements): _____
_____
_____
_____
Drug Allergies: _____

MEDICAL HISTORY

¤ High Cholesterol	¤ Rheumatic Fever	¤ High Blood Pressure	¤ Heart Attack
¤ Tuberculosis	¤ Epilepsy	¤ Pneumonia	¤ Heart Murmur
¤ Diabetes	¤ Asthma	¤ Cancer	¤ Stroke
¤ Liver Disease	¤ Arthritis	¤ Swelling	¤ Prior Bypass (Year) _____
¤ Heart Failure	¤ Stomach Problems	¤ Varicose Veins	¤ Prior Stent (Year) _____
¤ Emphysema	¤ Ulcers	¤ Sleep Apnea	¤ Other Heart Surgery _____
¤ Thyroid Problem			
¤ Other: _____	¤ Other: _____	¤ Other: _____	¤ Other: _____

FAMILY MEDICAL HISTORY

¤ CAD Mother Father Sister Brother	¤ Hypertension Mother Father Sister Brother	¤ Stroke Mother Father Sister Brother
¤ Lung Disease M F S B	¤ Liver Disease M F S B	¤ Cancer M F S B
¤ Tuberculosis M F S B	¤ Diabetes M F S B	¤ 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:
¤ Fever
¤ Itchy Skin
¤ Chills
¤ Insomnia
¤ Night Sweats
¤ Changes in hair
¤ Constant Fatigue
¤ Changes in Mood
¤ Weakness
¤ Changes in Skin

RESPIRATORY:
¤ Head Colds
¤ Sore Throat
¤ Runny Nose
¤ Hoarseness
¤ Post Nasal Drip
¤ Short of Breath
¤ Nasal Blockage
¤ Chronic Cough
¤ Sinus Problems
¤ Bloody Sputum

M/S-NUERO:
¤ Extreme backache
¤ Joint Pain
¤ Joint Swelling
¤ Pain or Numbness
¤ Broken Bones
¤ Cramps
¤ Loss of Balance
¤ Severe Headaches
¤ Coordination Problems
¤ Dizziness

VISION:
¤ Eye Pain
¤ Glasses
¤ Contact Lenses
¤ Double Vision
¤ Glaucoma
¤ Cataracts
¤ Floaters in Eye

ENDOCRINE:
¤ Excessive Thirstiness
¤ Hungry after meals
¤ Frequent Urination

CARDIOVASCULAR:
¤ Chest Pain
¤ Leg/Ankle Swelling
¤ Fast/Slow Heart Beat
¤ Shortness of Breath with Activity
¤ Shortness of Breath while laying down
¤ Shortness of Breath with sleeping

WOMEN:
Do you still have menstrual periods? Yes No
Last Period: _____
Last Pap Smear: _____

Patient Signature: _____ **Date:** _____