OSF HEALTHCARE
Cardiovascular Institute

Patient History

Please complete this form at home before you come to your appointment with us. If you need assistance with the form, come early for your appointment and tell our receptionist that you would like help. She will be happy to call on one of our nurses to help you. **Please bring the bottles of all prescription and over-the counter drugs you are currently taking.**

Name ______________________ Age _____ Today's Date ______________

Date of Birth ______________________

Reason for Consultation ______________________

Family Dr. ______________________

Referring Dr. (if different than family) ______________________ Office Phone ______________

In your own words, what kind of problems are you having? ______________________

____

please continue to next page

CARDIOLOGIST'S NOTES

Whom interviewed:

Patient ______________

Relative ______________

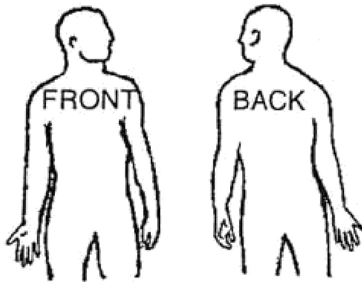
Other ______________

PATIENT HISTORY

Name: ____________________

A. HISTORY OF PRESENT ILLNESS

1. Pain/Discomfort
   a. Location (shade area(s)



   b. Type of discomfort:
   - ☐ Pressure/heaviness
   - ☐ "Gas"
   - ☐ tightness
   - ☐ Sharp/stabbing
   - ☐ Dull ache
   - Other: ____________________

   c. Severity
   - ☐ Mild
   - ☐ Moderate
   - ☐ Severe

   d. How long does it last?
   - ☐ Less than 1 minute
   - ☐ 1-5 minutes
   - ☐ 5-30 minutes
   - ☐ More than 30 minutes
   - ☐ Days

   e. Is it associated with:
   - ☐ Sweating
   - ☐ Shortness of breath
   - ☐ Nausea/vomiting
   - ☐ Dizziness
   - ☐ Worse with a deep breath or cough
   - ☐ None of these

   f. Does it come on with:
   - ☐ Exertion or exercise
   - ☐ At rest
   - ☐ At night
   - ☐ No pattern

   g. Is it helped by:
   - ☐ Nitroglycerin
   - ☐ Antacids
   - ☐ Food
   - ☐ Time
   - ☐ Rest
   - ☐ Other: ____________________

2. Are you experiencing shortness of breath?
   ☐ No (go to #3) ☐ Yes, if yes is it . . . ?
   - ☐ Continuous
   - ☐ With exertion
   - ☐ Awakens you at night
   - ☐ Worse on lying down
   - ☐ No pattern
   - ☐ Other ____________________

3. Heart skipping or racing: If yes,
   ☐ No (go to #4) ☐ Yes, if yes is it . . . ?
   - ☐ At rest
   - ☐ With exertion/exercise
   - ☐ No pattern
   - ☐ Other ____________________

   Frequency:
   - ☐ Daily
   - ☐ At least weekly
   - ☐ At least monthly
   - ☐ Rarely (less than monthly)

4. Have you had blackouts or near blackouts?
   ☐ No ☐ Yes, If yes:
   - ☐ Does it occur with no warning?
   - ☐ You can tell its coming!
   - ☐ Was it associated with heart skipping/racing?

   Frequency:
   - ☐ Daily
   - ☐ At least weekly
   - ☐ At least monthly
   - ☐ Rare or only once

   Has it ever been witnessed by someone?:
   ☐ No ☐ Yes If yes, whom ____________________

5.

NO	YES	
☐	☐	1. Do you have pain, cramping or aching in the buttocks, thighs or calves while walking?
☐	☐	2. Do these symptoms get better at rest?
☐	☐	3. Have you ever been told you have peripheral vascular disease?
☐	☐	4. Have you ever had nonhealing ulcers on your legs or toes?
		(MALES ONLY)
☐	☐	5. Do you have problems with erectile dysfunction (impotence)?

B. YOUR PAST MEDICAL HISTORY

Name: ______________________

1. Previous illnesses

- ☐No ☐Yes Have you ever had a heart attack? If yes, when?
- ☐No ☐Yes Have you ever had a coronary angiogram (heart cath)? If yes, when? ______________
- ☐No ☐Yes Have you ever had a balloon angioplasty or stent? If yes, when? ______________
- ☐No ☐Yes Have you ever had bypass or other heart surgery? If yes, when? ______________ Where? ______________
- ☐No ☐Yes Have you had any surgeries? If yes:

What operation?	Year	Where (Hospital)

Other hospitalizations:

For What?	Year	Where

Have you had or do you have any of the following medical problems?

No	Yes	
☐	☐	Glaucoma
☐	☐	Rheumatic fever
☐	☐	Diagnosis of coronary artery disease
☐	☐	Blood vessel disease, or blockage of aorta, legs, or neck arteries
☐	☐	Blood clots in your legs or lungs
☐	☐	Emphysema or chronic bronchitis
☐	☐	Gallstones
☐	☐	Ulcer

No	Yes	
☐	☐	Intestinal bleeding
☐	☐	Kidney stones
☐	☐	Other kidney disease, if yes, what? ______________
☐	☐	Osteoporosis
☐	☐	Rheumatoid arthritis
☐	☐	Prostate problems
☐	☐	Menopause, if yes age________
☐	☐	Hepatitis/yellow jaundice

No	Yes	
☐	☐	Stroke or TIA, "ministrokes"
☐	☐	Epilepsy/seizure
☐	☐	Suicide attempt
☐	☐	Thyroid problems
☐	☐	Anemia, if yes did you ever require transfusion?
☐	☐	Tuberculosis (TB)
☐	☐	AIDS, or positive HIV
☐	☐	Cancer, if yes, where? ______________

No	Yes	
☐	☐	Bleeding disorder
☐	☐	High blood pressure
☐	☐	Diabetes
☐	☐	High cholesterol
☐	☐	High triglycerides
☐	☐	Other: ______________

2. ☐No ☐Yes **<u>Allergies</u>**, if yes;
   - ☐ X-ray dye (IVP, angiogram); type of reaction ______________
   - ☐ Shellfish
   - ☐ Foods, which: ______________
   - ☐ Latex
   - ☐ Medicines: if yes,

Name	Type of reaction

C. **CURRENT MEDICINES** (prescription and over-the-counter) Name: ____________________

Name	dosage (mg)	How many times a day do you take it?

D. REVIEW OF SYSTEMS (also see section A)

1. Constitutional

No Yes
- ❐ ❐ Weight loss: ______lbs. in _____mos.
- ❐ ❐ Weight gain: _____ lbs. in _____ mos.
- ❐ ❐ Chronic fatigue
- ❐ ❐ Frequent headaches
- ❐ ❐ Other ____________________

2. Head, eyes, ears, nose, throat

No Yes	No Yes
❐ ❐ Double vision	❐ ❐ Blurred vision
❐ ❐ Sudden loss of vision	❐ ❐ Frequent nosebleeds
❐ ❐ Hearing loss	❐ ❐ Sinus problems
❐ ❐ Dentures	❐ ❐ Other:__________
❐ ❐ Dental cavities	__________

3. Cardiovascular (see section 1)

No Yes	No Yes
❐ ❐ Leg/ankle swelling	❐ ❐ Leg ulcers
❐ ❐ Leg pain w/walking	❐ ❐ Varicose veins

4. Respiratory

No Yes	No Yes
❐ ❐ Wheezing	❐ ❐ Frequent cough
❐ ❐ Asthma	❐ ❐ Snoring
❐ ❐ Coughing blood	

Other:____________________

5. Gastrointestinal

No Yes	No Yes
❐ ❐ Trouble swallowing	❐ ❐ Frequent constipation
❐ ❐ Heartburn/ indigestion	❐ ❐ Frequent diarrhea
❐ ❐ Hemorrhoids	❐ ❐ Blood in stool
❐ ❐ Black bowel movements	Other:__________

6. Genitourinary

No Yes	No Yes
❐ ❐ Bladder trouble	❐ ❐ Hot flashes
❐ ❐ Blood in urine	❐ ❐ Trouble passing urine

Other:____________________

7. Musculoskeletal

No Yes	No Yes
❐ ❐ Joint aches/pains	❐ ❐ Arthritis
❐ ❐ Muscle aches	❐ ❐ Trouble walking

Other:____________________

8. Neurologic

No Yes	No Yes
❐ ❐ Loss of ability to speak (even briefly)	❐ ❐ Confusion
	❐ ❐ Loss of control of arm or leg
❐ ❐ Balance problems	
❐ ❐ Dizzy spells	❐ ❐ Migraine headache
❐ ❐ Falls asleep/dozes off inadvertently at other times	❐ ❐ Kicking in sleep
	❐ ❐ Difficulty falling asleep
	❐ ❐ Difficult staying asleep

Other:____________________

9. Psychiatric

No Yes	No Yes
❐ ❐ Anxiety	❐ ❐ Depression
❐ ❐ Panic attacks	❐ ❐ Thoughts of suicide

10. Endocrine (glands)

No Yes	No Yes
❐ ❐ Cold intolerance	❐ ❐ Loss of sex drive
❐ ❐ Heat intolerance	

11. Hematology

No Yes	No Yes
❐ ❐ Severe anemia	❐ ❐ Bleeding problems
❐ ❐ Easy bruising	

12. Skin

No Yes	No Yes
❐ ❐ Breast problems	❐ ❐ Hives
❐ ❐ Shingles	❐ ❐ Rashes

E. YOUR FAMILY HISTORY

	Age	State of health if living	If deceased: Age	Cause
Mother				
Father				
Brother/Sister				
Brother/Sister				
Brother/Sister				

Is there a family history of any of the following?

☐No ☐Yes Sudden, unexpected death; if yes, who? ______

☐No ☐Yes High cholesterol; if yes, who? ______

☐No ☐Yes Diabetes; if yes, who? ______

☐No ☐Yes High blood pressure; if yes, who? ______

☐No ☐Yes Cancer; if yes, who? ______

E. SOCIAL HISTORY

Marital status: ☐Married ☐Widowed ☐Divorced ☐Single

If married, spouse's name______ age ______ health status ______

Children: _____Sons _____Daughters ☐No children any deceased: ☐No ☐Yes:

If yes, cause(s):______

Occupation______ Previous occupation______

Education: Years of elementary (1-8) ______ high school (1-4) ______ college/business: ______

Do you live: ☐ In your own home ☐ In a nursing home ☐ In Assisted Living

☐ With a family member in their home ☐ Other ______

Habits:

Tobacco use:

☐Cigarettes # of packs/day______; How many years? ______; ☐Quit, date: ______

☐Cigars # ______/day; ☐Quit, date: ______ ☐Pipe # ______/day; ☐Quit, date: ______

Alcohol: ☐Never ☐Quit ☐Yes: drinks per day____

Caffeine: ☐Never Coffee: ____ # cups/day Soda: ____ # cans/day Tea: ____#cups/day

Do you exercise? ☐Yes ☐No How often? ______ How long per session? ______

What type of exercise do you do? ______