PERSONAL HISTORY – Cardiology/Endocrinology/Sleep

Name _____ Today's Date_____
Age _____ Date of Birth _____ Referring Physician _____

Reason for this appointment / description of your symptoms:

Past Medical Illnesses – check any that apply to you

Asthma		Cancer or Tumor		Kidney Stones		Multiple sclerosis		None	
Arthritis		Reflux esophagitis		Gallbladder disease		Prostate problems			
Emphysema		Diverticulitis		Lupus (SLE)		Ankylosing Spondylitis			
Blood clot-lung		Stomach Ulcers		Sjogren's syndrome		Thyroid problems			
Blood clot-leg		Crohn's disease		Fibromyalgia		Osteoporosis			
Pulmonary hypertension		Ulcerative colitis		Psoriasis		Diabetes			
Bleeding disorder		Pancreatitis		Rheumatoid arthritis		Sleep Apnea			
Anemia		Kidney disease		Gout					

Any other conditions you see a doctor for_____

Past Cardiovascular Illnesses – check any that apply to you

High blood pressure		Heart attack		Heart failure		Irregular heartbeat		None	
High cholesterol		Heart murmur		Atrial fibrillation		Blood flow problem to legs			
High triglycerides		Stroke		Ventricular tachycardia		Blood flow problem to neck			
Coronary disease									

Infectious History - check any that apply to you

Chicken Pox		Measles		Mumps		Hepatitis		Other		None	
Rheumatic fever		TB or positive TB test		Scarlet fever							

Other History	Type	Year	Location
Trauma or accident			
Surgeries			
Cardiology Procedures – heart cath, angioplasty			
Cardiology Tests – treadmill, echocardiogram, nuclear scan, MRI			
Electrophysiology Procedures			
Device Implants (pacemakers, defibrillators)			
Peripheral – any surgery, angioplasty, stents to blood vessels (not heart)			
Thyroid Testing			

Other Testing

Colonoscopy		Dexa Scan		Pulmonary functions		Sleep Study	

Family History Approximate age at diagnosis. Specify if Paternal or Maternal

	Mother	Father	Sibling	Cousin, Aunt, Uncle	Grandparent
Heart disease					
Diabetes					
Congenital deafness					
Sudden cardiac death before age 30					
Aortic aneurysm					
Stroke					
Other					

Social History

Do you use Alcohol? ___Never ___Occasional ___Frequently
Smoker? ___Yes ___No ___ Past How many per day?_____
Special Diet? _____
Caffeine use _____ How many per day? _____
Caffeine 4 hours prior to bed at night? ____yes ____no
Exercise? ___Routine ___Occasional ___None
Substance Use?_____
Lifestyle ___Married ___Single ___Widower ___Divorced
Job description _____

Allergies

Substance	Reaction	Substance	Reaction

Have you ever had an allergic reaction to x-ray contrast or iodine?

Medications (Include prescription, supplements, regular over-the-counter medications)

Name	Dose	Name	Dose

Preferred Pharmacy _____

Any Other Comments _____
_____
_____