

FIRST COAST CARDIOVASCULAR INSTITUTE, P.A.

(904) 493-3333 www.firstcoastcardio.com

MR# _____

PATIENT HISTORY FORM

(Please print, fill out, and bring to your visit)

Appointment Date _____ Name _____

Appointment Time _____ Referring Physician _____

Date of Birth _____ Social Security # _____ / _____ / _____

Cardiovascular Specialist seen in the past? Who? _____ When? _____

Which cardiovascular specialist(s) are you coming to see at our office? Please check one or more.

Ashchi Khatib Ali Lamba Shah Al-Saghir Grech Hayes

Caracciolo Pubbi Zuberi Lokhandwala Ahmed (Sleep) Parikh (Neurology)

PHYSICIANS

List all doctors providing care

Doctor's Name	Type of Doctor <i>Primary Care, Urologist, etc</i>	Reason for seeing this doctor
	Primary Care Doctor	

ALLERGIES

Do you have allergies to drugs, food, latex, dye? YES NO

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc

♥ BRING all medications in their original containers to every appointment!

Medication Name	Dosage	How often do you take?	Prescribing Physician
PLEASE ATTACH COPY OF ALL MEDICATIONS		PLEASE ATTACH COPY OF ALL MEDICATIONS	

REVIEW OF SYSTEMS

Circle if you are experiencing symptoms or check "No Symptoms"

<p>General</p> <p><input type="checkbox"/> No Symptoms</p> <p>Decreased appetite</p> <p>Fever</p> <p>Recent weight loss/gain</p> <p>Integumentary (Skin)</p> <p><input type="checkbox"/> No Symptoms</p> <p>Rash</p> <p>Eyes</p> <p><input type="checkbox"/> No Symptoms</p> <p>Blurred vision</p> <p>Double vision</p> <p>Ears, Nose, and Throat</p> <p><input type="checkbox"/> No Symptoms</p> <p>Difficulty speaking</p> <p>Hearing loss</p> <p>Hoarseness</p> <p>Nose bleeds</p>	<p>Respiratory</p> <p><input type="checkbox"/> No Symptoms</p> <p>Cough</p> <p>Coughing up blood</p> <p>Wheezing</p> <p>Cardiovascular</p> <p><input type="checkbox"/> No Symptoms</p> <p>Chest pain, pressure or tightness</p> <p>Fainting</p> <p>Heart palpitations (racing)</p> <p>History of blood clots /phlebitis</p> <p>Irregular heart beats</p> <p>Non healing sores on legs or feet</p> <p>Pain in legs with walking</p> <p>Short of breath lying flat</p> <p>Swelling of feet or ankles</p> <p>Waking with shortness of breath</p> <p>Gastrointestinal System</p> <p><input type="checkbox"/> No Symptoms</p> <p>Blood in stool</p> <p>Black stools</p> <p>Difficulty swallowing solids</p> <p>Difficulty swallowing liquids</p> <p>Heartburn</p>	<p>Genitourinary</p> <p><input type="checkbox"/> No Symptoms</p> <p>Blood in urine</p> <p>Pain with urination</p> <p>Neurological</p> <p><input type="checkbox"/> No Symptoms</p> <p>Headaches</p> <p>Numbness/tingling on one side</p> <p>Weakness on one side</p> <p>Endocrine</p> <p><input type="checkbox"/> No Symptoms</p> <p>Excessive thirst</p> <p>Increased urination</p> <p>Hematological</p> <p><input type="checkbox"/> No Symptoms</p> <p>Bleed easily</p> <p>Bruise easily</p>
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PAST MEDICAL HISTORY

Circle past history

Past Illnesses	Past Cardiac Illnesses	Past Surgeries/Procedures
Asthma 493.90	Angina 413.9	Appendectomy v45.72
Bronchitis/Emphysema 490	Chest Pain 786.50	Back v15.29
Cancer? Type? _____ v10.9_	Atrial Fibrillation or Flutter 427.31	Breast v45.74
Diabetes 250.00	Congestive Heart Failure (CHF) 428.0	Cataract v45.61
How long? _____	Coronary Artery Disease 414.00	Gallbladder v45.79
Kidney Stones 592.9	Heart Attack (MI) 412	Hiatal Hernia v15.29
Kidney Failure 586	High Blood Pressure 401.9	Inguinal Hernia v15.29
Hemodialysis v45.1	High Cholesterol 275.9	Hip v43.46
Liver Disorder 573.9	Irregular heartbeat (arrhythmias) 427.9	Hysterectomy v45.77
Gallbladder Disorder 575.9	Peripheral Vascular Disease 443.9	Intestinal v45.72
Peptic Ulcer 533.9	Valvular heart disease 424.1	Gastric bypass v45.86
GERD 530.81	Mitral Valve Disorder 424.0	LapBand v45.86
Prostate 602.9	Tricuspid Valve Disorder 424.2	Knee v43.65
Rheumatic Fever 390	Other : _____	Ankle v43.66
Seizures 345.90	_____	Prostate v45.77
Sleep Apnea 780.57	_____	Tonsils/Adenoids v45.79
Stroke/CVA 436	_____	Sleep Apnea Surgery v45.37
Thyroid Disease 246.9		Other: _____
Hypothyroid 244.9		_____

Infectious Disease History Hepatitis? 573.3 HIV? Not active v08. Other: _____ _____ _____ Trauma History Accident _____ _____ _____	Past Vascular history/Procedure? Leg or arm angioplasty? v43.4 Leg or Arm stent? v43.4 Leg or arm clots? VEIN v12.51 ARTERY CLOT v12.9 Kidney artery angioplasty? Stent? v43.4 Stomach artery angioplasty/Stent? v43.4 Stroke 436 TIA? 435.8 Carotid stent v43.4 Carotid surgery v43.4 Blood disorder or clotting history? v12.3 Lung Clot(Pulmonary Embolism) v12.51 Aneurysm anywhere in the body? v12.59 Had a filter placed for clots (IVCF)? v43.4 Foot, arm or leg ulcer? 707.9	Past Cardiac Surgery/Procedures Cardiac Cath Cardioversion Coronary Angioplasty v45.82 Coronary Stent v43.4 Coronary Artery Bypass v45.81 How many? _____ Where? _____ When? _____ EP Study AICD(defibrillator) v45.02 Pacemaker Implant v45.01 Radiofrequency Ablation Heart Valve Surgery v43.3 When? _____
Others?		

SOCIAL HISTORY AND LIFESTYLE

Alcohol Use Yes / No Do you consume any type of alcohol? Moonshine? Average number per day ___ Beer ___ Wine ___ Liquor Smoking/Tobacco Use Yes / No Do you smoke or use tobacco? Yes / No Have you smoked in the past? Number of Years? ___ Packs per day ___ Diet Yes / No Are you on a special diet? What type of diet? _____ Yes / No Do you drink caffeinated beverages? (<i>coffee, tea, cola</i>) How many daily? _____ Exercise Yes / No Do you exercise on a regular basis? Minimum of 30 minutes / 3 times a week Substance Abuse Yes / No Do you have a history of any drug use? If yes, specify: _____	Lifestyle <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated Occupation _____ <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed Residence <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with children <input type="checkbox"/> Lives with parents <input type="checkbox"/> Lives with spouse <input type="checkbox"/> Lives with spouse/children <input type="checkbox"/> Lives with male partner <input type="checkbox"/> Lives with female partner <input type="checkbox"/> Nursing home resident <input type="checkbox"/> Assisted living resident
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FAMILY MEDICAL HISTORY

Family Cardiac History Father <input type="checkbox"/> Alive <input type="checkbox"/> Heart attack before age 60 <input type="checkbox"/> Deceased <input type="checkbox"/> Stroke v17.1 at age _____ <input type="checkbox"/> Sudden cardiac death v17.41 Mother <input type="checkbox"/> Alive <input type="checkbox"/> Heart attack before age 60 <input type="checkbox"/> Deceased <input type="checkbox"/> Stroke v17.1 at age _____ <input type="checkbox"/> Sudden cardiac death v17.41	Personal Cardiac Risk Factors <input type="checkbox"/> History of tobacco use v15.82 <input type="checkbox"/> Family history heart disease v17.3 (<i>immediate family</i>) <input type="checkbox"/> History high cholesterol 275.9 <input type="checkbox"/> High blood pressure 401.9 <input type="checkbox"/> History of diabetes 250.00
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Family Cardiac History (cont.)		Personal Cardiac Risk Factors (cont.)	
Sibling(s)			
Number of Brother(s)			
# _____ Alive	<input type="checkbox"/> Heart attack before age 60	<input type="checkbox"/> Prior history of heart disease	414.00
# _____ Deceased	<input type="checkbox"/> Stroke v17.1	<input type="checkbox"/> History of obesity	278.00
at age(s) _____	<input type="checkbox"/> Sudden cardiac death v17.41	<input type="checkbox"/> Sedentary lifestyle	
Number of Sister(s)		<input type="checkbox"/> Age (<i>Male over 45 - Female over 55</i>)	
# _____ Alive	<input type="checkbox"/> Heart attack before age 60	<input type="checkbox"/> Menopausal female	627.9
# _____ Deceased	<input type="checkbox"/> Stroke v17.1	<input type="checkbox"/> Polycystic Ovarian disease	256.4
at age(s) _____	<input type="checkbox"/> Sudden cardiac death v17.41	<input type="checkbox"/> Low HDL / High Triglyceride	272.9
		<input type="checkbox"/> Homocysteine Level problems	270.4

*** Our cardiovascular specialists have privileges at Baptist Hospital Downtown, Baptist South, Memorial Hospital Jacksonville, Orange Park Medical Center, Specialty Hospital, St. Luke's Hospital and Brooks Rehabilitation Hospital. If you, or a family member, are admitted to these hospitals, please ask the ER doctors or admitting doctors for our doctors so we may provide you with the continuous excellent care you have always enjoyed with our group. We are on call for our patients 24/7 at these locations. Our group provides you with board certified cardiologists and vascular specialists in several first coast area locations (see our website). Please visit our web site for educational material on cardiac and vascular medicine and the procedures we perform: learn about our research, and see photos of the **first** outpatient cardiac and vascular catheterization laboratory in the first coast. We strive for excellence. Please let us know how we can serve you better each time.

Signature _____

Date _____