

First Coast Cardiovascular Institute, PA

(904) 493-3333 www.firstcoastcardio.com

PATIENT HISTORY FORM

(Please print, fill out, 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 specialties are you coming to see at our office? Please circle one or more.

Ashchi Khatib Ali Lamba Al-Saghir Grech Shah Rai Pubbi Hayes Caracciolo

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

CURRENT MEDICATIONS List all vitamins, prescription medications, and over-the-counter medications.

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

Medication Name	Dosage	How often do you take?	Prescribing Physician

REVIEW OF SYSTEMS

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

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

Circle past history

<p>Past Illnesses</p> <table> <tr><td>Asthma</td><td>493.90</td></tr> <tr><td>Bronchitis/Emphysema</td><td>490</td></tr> <tr><td>Cancer? Type?</td><td>V10.9_____</td></tr> <tr><td>Diabetes,</td><td>250.00</td></tr> <tr><td>How long?</td><td>_____</td></tr> <tr><td>Kidney stones</td><td>592.9</td></tr> <tr><td>kidney failure</td><td>586</td></tr> <tr><td>Hemodialysis</td><td>V45.1</td></tr> <tr><td>Liver 573.9</td><td>Gallbladder 575.9</td></tr> <tr><td>Peptic Ulcer</td><td>533.90</td></tr> <tr><td>GERD</td><td>530.81</td></tr> <tr><td>Prostate</td><td>602.9</td></tr> <tr><td>Rheumatic Fever</td><td>390</td></tr> <tr><td>Seizures</td><td>345.90</td></tr> <tr><td>Sleep Apnea</td><td>780.57</td></tr> <tr><td>Stroke/CVA</td><td>436</td></tr> <tr><td>Thyroid Disease</td><td>246.9</td></tr> <tr><td>Hypothyroid</td><td>244.9</td></tr> </table>	Asthma	493.90	Bronchitis/Emphysema	490	Cancer? Type?	V10.9_____	Diabetes,	250.00	How long?	_____	Kidney stones	592.9	kidney failure	586	Hemodialysis	V45.1	Liver 573.9	Gallbladder 575.9	Peptic Ulcer	533.90	GERD	530.81	Prostate	602.9	Rheumatic Fever	390	Seizures	345.90	Sleep Apnea	780.57	Stroke/CVA	436	Thyroid Disease	246.9	Hypothyroid	244.9	<p>Past Cardiac Illnesses</p> <table> <tr><td>Angina</td><td>413.9</td></tr> <tr><td>Chest Pain</td><td>786.50</td></tr> <tr><td>Atrial Fibrillation or flutter</td><td>427.31</td></tr> <tr><td>Congestive heart failure (CHF)</td><td>428.0</td></tr> <tr><td>Coronary artery disease</td><td>414.00</td></tr> <tr><td>Heart Attack (MI)</td><td>412</td></tr> <tr><td>High Blood Pressure</td><td>401.9</td></tr> <tr><td>High Cholesterol</td><td>275.9</td></tr> <tr><td>Irregular heartbeat (arrhythmias)</td><td>427.9</td></tr> <tr><td>Peripheral Vascular Disease</td><td>443.9</td></tr> <tr><td>Valvular heart disease AV</td><td>424.1</td></tr> <tr><td>MV</td><td>424.0</td></tr> <tr><td>TV</td><td>424.2</td></tr> </table> <p>Other _____</p> <hr/> <p>Past Vascular history/Procedure?</p> <table> <tr><td>Leg or arm Angioplasty ?</td><td>Stent? V43.4</td></tr> <tr><td>Leg or arm clots? VEIN</td><td>V12.51</td></tr> <tr><td>ARTERY clot</td><td>V12.59</td></tr> </table>	Angina	413.9	Chest Pain	786.50	Atrial Fibrillation or flutter	427.31	Congestive heart failure (CHF)	428.0	Coronary artery disease	414.00	Heart Attack (MI)	412	High Blood Pressure	401.9	High Cholesterol	275.9	Irregular heartbeat (arrhythmias)	427.9	Peripheral Vascular Disease	443.9	Valvular heart disease AV	424.1	MV	424.0	TV	424.2	Leg or arm Angioplasty ?	Stent? V43.4	Leg or arm clots? VEIN	V12.51	ARTERY clot	V12.59	<p>Past Surgeries/Procedures</p> <table> <tr><td>Appendectomy</td><td>V45.72</td></tr> <tr><td>Back</td><td>V15.29</td></tr> <tr><td>Breast</td><td>V45.71</td></tr> <tr><td>Cataract</td><td>V45.61</td></tr> <tr><td>Gallbladder</td><td>V45.79</td></tr> <tr><td>Hernia – Hiatal/Inguinal</td><td>V15.29</td></tr> <tr><td>Hip</td><td>V43.64</td></tr> <tr><td>Hysterectomy</td><td>V45.77</td></tr> <tr><td>Intestinal</td><td>V45.72</td></tr> <tr><td>Gastric bypass/lap band</td><td>V45.86</td></tr> <tr><td>Knee</td><td>V43.65/</td></tr> <tr><td>ankle</td><td>V43.66</td></tr> <tr><td>Prostate</td><td>V45.77</td></tr> <tr><td>Tonsils/Adenoids</td><td>V45.79</td></tr> <tr><td>Sleep Apnea type of surgery</td><td>V45.79</td></tr> </table> <p>Other _____</p> <hr/>	Appendectomy	V45.72	Back	V15.29	Breast	V45.71	Cataract	V45.61	Gallbladder	V45.79	Hernia – Hiatal/Inguinal	V15.29	Hip	V43.64	Hysterectomy	V45.77	Intestinal	V45.72	Gastric bypass/lap band	V45.86	Knee	V43.65/	ankle	V43.66	Prostate	V45.77	Tonsils/Adenoids	V45.79	Sleep Apnea type of surgery	V45.79
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<p>_____</p> <p>Infectious Disease History Hepatitis? 573.3 HIV not active V08</p> <hr/> <p>Trauma History accident _____</p> <hr/>	<p>Kidney artery angioplasty? stent? V43.4 Stomach artery angioplasty/stent? V43.4 Stroke 436 or TIA 435.8? Carotid Stent V43.4 or surgery? Blood disorder or clotting history? V12.3 Lung clot or (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</p>	<p>Past Cardiac Surgery/Procedures Cardiac Cath Cardioversion Coronary angioplasty V45.82 Coronary Stent V43.4 Coronary artery bypass, V45.81 How many?__ Where?_____ When?_____</p> <p>EP Study AICD(defibrillator) V45.02 Pacemaker implant V45.01 RF ablation Heart Valve surgery, Replaced V43.3 when ?_____</p>
Others?		

SOCIAL HISTORY AND LIFESTYLE

<p>Alcohol Use Yes / No Do you consume any type of alcohol? Moonshine? Average number per day ___ Beer ___ wine ___ liquor</p> <p>Smoking/Tobacco Use Yes / No Do you smoke or use tobacco? (Yes 305.1) Yes / No Have you smoked in the past? Number of Years? _____ Packs per day _____</p> <p>Diet Yes / No Are you on a special diet? What type of diet? _____ Yes / No Do you drink caffeinated beverages? (<i>coffee, tea, cola, etc</i>) How many daily? _____</p> <p>Exercise Yes / No Do you exercise on a regular basis? Minimum of 30 minutes / 3 times a week</p> <p>Substance Abuse Yes / No Do you have a history of any drug dependency? If yes, specify: _____</p>	<p>Lifestyle <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated</p> <p>Occupation _____ <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed</p> <p>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</p>
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FAMILY MEDICAL HISTORY

<p style="text-align: center;">Family Cardiac History</p> <p>Father</p> <p><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</p>	<p>Personal Cardiac Risk Factors</p>
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Mother			
<input type="checkbox"/> Alive	<input type="checkbox"/> Heart attack before age 60	<input type="checkbox"/> History of tobacco use	V15.82
<input type="checkbox"/> Deceased	<input type="checkbox"/> Stroke V17.1	<input type="checkbox"/> Family history heart disease	V17.3
at age _____	<input type="checkbox"/> Sudden cardiac death V17.41	<i>(immediate family)</i>	
Sibling(s)		<input type="checkbox"/> History high cholesterol	275.9
Number of Brother(s)		<input type="checkbox"/> High blood pressure	401.9
# _____ Alive	<input type="checkbox"/> Heart attack before age 60	<input type="checkbox"/> History of diabetes	250.00
# _____ Deceased	<input type="checkbox"/> Stroke V17.1	<input type="checkbox"/> Prior history of heart disease	414.00
at age(s) _____	<input type="checkbox"/> Sudden cardiac death V17.41	<input type="checkbox"/> History of obesity	278.00
Number of Sister(s)		<input type="checkbox"/> Sedentary lifestyle	
# _____ Alive	<input type="checkbox"/> Heart attack before age 60	<input type="checkbox"/> Age (<i>Male over 45 - Female over 55</i>)	
# _____ Deceased	<input type="checkbox"/> Stroke V17.1	<input type="checkbox"/> Menopausal female	627.9
at age(s) _____	<input type="checkbox"/> Sudden cardiac death V17.41	<input type="checkbox"/> Polycystic Ovarian disease	256.4
		<input type="checkbox"/> Low HDL / High Triglyceride	272.9
		<input type="checkbox"/> Homocysteine Level problems	270.4

*** Our cardiovascular specialist have privileges at Baptist Hospital downtown , Baptist Beaches, Baptist South , Memorial Hospital Jacksonville, Orange Park Hospital, Specialty Hospital, Brooks Rehabilitation Hospital , Flagler Hospital . If you are or family member 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 always enjoyed with our group. We are on call for our patients 24/7 at these locations. Our group provides you with board certified cardiologist and vascular specialist in several first coast area locations (see web). Please visit our web site for educational material on cardiac vascular medicine and the procedures we perform, learn about our research, see photos of the **first** outpatient cardiac and vascular catheterization laboratory in the first coast. We strive to for excellence. Please let us know how we can serve you better each time.

Signature _____

Date _____