CARDIAC STUDY CENTER, INC., P.S.

New Patient Medical History

Tacoma (253) 572-7320 - Puyallup (253) 841-4347 - Lakewood (253) 588-7778 - Gig Harbor (253) 851-0404

PATIENT IDENTIFICATION

Last Name	First Name	MI	Date
Social Security Number	Date of Birth		
Primary Care Provider	Who referred you to us?		
Please state the main reason you have come here to see a cardiologist.			
Is this a new or old condition? Please explain.			

HEART RELATED PAST MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE BELOW DISEASES/ ILLNESSES?

Diabetes	Yes	No	Stroke (CVA) or mini-stroke (TIA)	Yes	No
High blood pressure	Yes	No	Heart valve disease	Yes	No
High cholesterol	Yes	No	Murmur	Yes	No
Coronary artery disease (ischemic heart disease)	Yes	No	Aneurysm	Yes	No
Heart attack (myocardial infarction)	Yes	No	Pulmonary embolism	Yes	No
Heart failure (cardiomyopathy)	Yes	No	Rheumatic fever	Yes	No
Arrhythmia (heart rhythm problem)	Yes	No	COPD (emphysema)	Yes	No
Congenital heart disease	Yes	No	Cancer	Yes	No

PLEASE LIST ALL YOUR *HEART RELATED* HOSPITALIZATIONS, PROCEDURES, AND OPERATIONS:

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OTHER PAST MEDICAL HISTORY

PLEASE LIST ALL YOUR OTHER MEDICAL PROBLEMS, SERIOUS ILLNESSES, HOSPITALIZATIONS, AND OPERATIONS:

SOCIAL HISTORY

Marital status	Single Married Divorced Widowed	Smoking history	Current Prior Never
		Illicit substance use in the last year	Yes No
Number of children	_____	Number of alcoholic drinks daily	_____
Most recent occupation:		Exercise type:	
Living will	Yes No	Exercise duration (min per session):	_____
Power of attorney	Yes No	Exercise frequency (times per week):	_____

FAMILY HISTORY

PLEASE CIRCLE ANY CONDITION(S) THAT HAS AFFECTED YOUR FOLLOWING FAMILY MEMBER:

Father	Mother	Siblings
Heart attack	Heart attack	Heart attack
Bypass surgery, angioplasty, or stents	Bypass surgery, angioplasty, or stents	Bypass surgery, angioplasty, or stents
Diabetes	Diabetes	Diabetes
High blood pressure	High blood pressure	High blood pressure
High cholesterol	High cholesterol	High cholesterol
Sudden cardiac death	Sudden cardiac death	Sudden cardiac death
Hypertrophic cardiomyopathy	Hypertrophic cardiomyopathy	Hypertrophic cardiomyopathy

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HEART AND CIRCULATION REVIEW OF HEALTH

HAVE YOU HAD ANY OF THE BELOW CONDITIONS RECENTLY?

Chest pain	Yes	No	Shortness of breath waking from sleep	Yes	No
Chest discomfort	Yes	No	Swelling in the legs	Yes	No
Shortness of breath at rest	Yes	No	Passing out (syncope)	Yes	No
Shortness of breath with exertion	Yes	No	Heart racing / pounding (palpitations)	Yes	No
Shortness of breath lying in bed	Yes	No	Pains in the legs with walking	Yes	No

How far can you walk before you have to stop? And why would you have to stop (what limits you)?

REVIEW OF GENERAL HEALTH

HAVE YOU HAD ANY OF THE BELOW CONDITIONS RECENTLY?

Change in weight	Yes	No	Vomiting	Yes	No
Dizziness	Yes	No	Bleeding from your rectum	Yes	No
Weakness	Yes	No	Blood in your urine	Yes	No
Fevers	Yes	No	Joint aches or pains	Yes	No
Chills	Yes	No	Muscle aches or pains	Yes	No
Fatigue	Yes	No	Seizures	Yes	No
Blurry vision	Yes	No	Strokes (CVA) or mini-strokes (TIA)	Yes	No
Bleeding from your nose	Yes	No	Skin sores or ulcers	Yes	No
Bleeding from your gums	Yes	No	Pain when pressing chest wall	Yes	No
Shortness of breath	Yes	No	Depression	Yes	No
Cough	Yes	No	Thyroid problems	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
COPD (emphysema)	Yes	No	Easy bruising	Yes	No
Nausea	Yes	No	Bleeding or clotting problems	Yes	No