OneHealth
A member of Owensboro Health

Cardiology

MR#_____

Patient Name _____ Date of Birth _____ Date _____

Medical Physician(s) _____

Who referred you or how did you hear about us? _____

History of Present Illness

What is the reason for today's visit? _____

Past Medical History

Have you ever had the following?

Arthritis	Yes	No	Dysrhythmia	Yes	No	Rheumatic Fever	Yes	No
Atrial Fibrillation	Yes	No	Heart Attack/Myocardial Infarction	Yes	No	Sleep Apnea	Yes	No
Bleeding Problems	Yes	No	Heart Failure	Yes	No	St Vitus Dance	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Cardiomyopathy	Yes	No	Hiatal Hernia	Yes	No	Thyroid Disease	Yes	No
Carotid Artery Disease	Yes	No	Hypertension	Yes	No	Tuberculosis	Yes	No
COPD	Yes	No	High Cholesterol	Yes	No	Ulcers	Yes	No
Diabetes Mellitus	Yes	No	Kidney Disease	Yes	No	Whooping Cough	Yes	No
Diptheria	Yes	No	Pain in Legs When Walking	Yes	No			
DVT	Yes	No	PVD (Peripheral Vascular Disease)	Yes	No			

Have you had any other medical problems diagnosed that we have not asked about? _____

_____

_____

Have you had any of the following medical services?

Holter Monitor	Yes	No	Angioplasty or Stent	Yes	No
Stress Test	Yes	No	CABG (Coronary Artery Bypass Surgery)	Yes	No
Echocardiogram	Yes	No	Pacemaker Insertion	Yes	No
Cardiac Catheterization	Yes	No	ICD (Defibrillator Insertion)	Yes	No

Surgeries or Hospitalizations Not Listed Above

_____

_____

_____

Allergies:_____

Local Anesthetic	No	Yes
X-ray Dye or Iodine	No	Yes
Shellfish	No	Yes

Family History

Check All That Apply

Relationship	Status	Anemia	Arrhythmia	Asthma	Clotting Disorder	CVA (Stroke)	Diabetes	Heart Attack	Heart Disease	Heart Failure	High Cholesterol	Hypertension
Mother												
Father												
Sister												
Brother												

Social History

Alcohol Use **Yes** **No**
Drinks/Week
___ ___ Glasses of Wine
___ ___ Cans of Beer
___ ___ Shots of Liquor
___ ___ Drinks Containing 0.5 oz of Alcohol
Comments _____
Alcohol/Week

Daily Caffeine Use **Yes** **No**
Cups/Day 1 2 3 4 5 _____per Day
Comments _____

Tobacco Use **Yes** **No** **Unknown**
Years 0.5 1 2 3 4 5 10 15 _____years
Packs/Day 0.25 0.5 1 1.5 2 3 _____ per Day
Quit Date _____

Smokeless Tobacco _____
Quit Date _____

Comment_____

Patient Social History

Marital Status: ____ Single ____ Married ____ Separated ____ Divorced ____ Widowed

Number of Children: _____ Occupation: _____