SeaCoast Cardiology Consultants, P.L.L.C.

MEDICAL HISTORY

Name:_____ Date:_____ Primary Physician:_____

CURRENT HEALTH

What is the main reason for your referral today? _____

_____

_____

Do you have any of the following symptoms? *Write "yes" or "no"*

Chest Pain or Pressure:
- -with exertion_____
- -at rest_____
- -at night_____

Irregular Heart Beat_____
Rapid Heart Beat_____
Any fainting spells_____
Frequent dizziness_____
Abdominal pain_____

Shortness of Breath:
- -with exertion_____
- -at rest_____
- -at night_____

Frequent coughing_____
Coughing up blood_____
Wheezing_____
Frequent indigestion_____
Swelling of legs/feet_____

Past Medical History: Have you ever had any of the following problems:

Heart attack_____	Phlebitis_____	Stroke_____
Angina_____	Asthma_____	Thyroid problems_____
Congestive Heart Failure_____	Tuberculosis_____	Cancer_____
Enlarged heart_____	Stomach ulcer_____	Bleeding disorder_____
Heart murmur_____	Gall stones_____	Severe arthritis_____
Rheumatic fever_____	Hepatitis_____	Diabetes_____
High blood pressure_____	Kidney stones_____	Pneumonia_____

Habits:

Current Tobacco Use:
How much?_____ How many years?_____

Past Tobacco Use:
How much?_____ How long?_____ Date quit_____

Alcohol Use:
How much?_____ How many years?_____

How often do you exercise?_____

Type of exercise_____

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Cardiovascular Operations or Procedures: ***(Please give approximate dates)***

	Date:	Hospital:	Number of Vessels:	Surgeon:
Coronary *"Bypass"* Surgery				
	Date:	**Hospital:**	**Number of Vessels:**	**Surgeon:**
Cardiac Catherization				
	Date:	**Hospital:**	**Number of Vessels:**	**Surgeon:**
PTCA *"Balloon"* Stents				

	Date:	Which Valve:	Hospital:
Heart Valve Surgery			

	Date:	Hospital:
Pacemaker		

Hospitalizations for Heart Problems: _____

_____

Hospital ER Visits: _____

_____

	Date:	Reason:	Location:
Other Hospitalizations			

	Date:	Reason:	Location:
Other Surgeries:			

Family History:

Father: Age____ Cardiac history _____

If deceased. Age____ Cause of death _____

Mother: Age____ Cardiac history _____

If deceased. Age____ Cause of death _____

Sibling Information: How many brothers_____ How many sisters_____

Please list Sex and Age of siblings with Cardiac History and if deceased, their age and cause of death:

_____

_____