DESERT
CARDIOLOGY CENTER
Devoted Heart Care Specialists

NEW PATIENT HISTORY AND PHYSICAL FORM

(Please complete and bring to your first visit)

Name of Patient: _____ Date of visit: _____
Last First M.I.

Date of Birth: _____ Age: _____ Sex: M ☐ F ☐ Height: _____ Weight: _____ lbs.

What medical problem or condition are you here to have evaluated? _____

Current Medications: (please list all prescription, non-prescription medications and nutritional supplements)

CURRENT MEDICATIONS	DOSE (Strength)	SCHEDULE (How many & times per day)	HOW LONG HAVE YOU TAKEN?
Example: Lopressor	50 mg	1 tablet, two times a day	6 months

Drug/Food Allergies:

Are you allergic to:	Yes	No	Please list all allergies to medications and other substances. Describe reaction they cause.
Any medications	☐	☐	
Iodine, fish or shellfish	☐	☐	
X-ray dye or IV contrast	☐	☐	
Can you tolerate aspirin?	☐	☐	

Social History

Do you have:	Yes	No
High blood pressure……	☐	☐
Diabetes……	☐	☐
Controlled with: ☐ Insulin, How long: _____ ☐ Pill ☐ Diet		
High cholesterol……	☐	☐
Family history of heart or vascular disease……	☐	☐
A history of Rheumatic Fever or Scarlet Fever……	☐	☐
Do you now or have you ever smoked tobacco products……		
Cigarettes: # of packs per day:……..... _____ # of years: _____		
Cigars:……	☐	☐
Pipes:…….....	☐	☐
When was your last cigarette, cigar or pipe?..... _____		

Do you:

	Yes	No
Do you drink alcohol on a regular basis?	☐	☐
If no, did you drink heavily in the past?	☐	☐
If yes, how much do you typically drink in one week?	_____	
Do you use recreational drugs?	☐	☐
Have you ever been treated for substance abuse?	☐	☐

Diet:

☐ Balanced ☐ Low fat low cholesterol ☐ Low salt ☐ No special diet

☐ Other, please describe: _____

Activity Level: which of the following best describes your level of physical activity both in your daily life and your leisure time

☐ Exercise strenuously on a regular basis
☐ Exercise moderately on a regular basis
☐ Exercise on an occasional basis
☐ Do not regularly exercise, but have an active lifestyle
☐ Have difficulty accomplishing light chores of daily living
☐ Require assistance to accomplish self-care

Have You Ever Had Any of the Following	Yes	No	Date or Year	Place (Hospital or City)	Complications/Problems
Exam by a Cardiologist (Heart Doctor)	☐	☐			
Heart Catheterization or Angiogram	☐	☐			
Coronary Angioplasty (PTCA/Balloon/Stents)	☐	☐			
Exercise Stress Test (Treadmill)	☐	☐			
Echocardiogram (Ultrasound of the Heart)	☐	☐			
Pacemaker/Defibrillator	☐	☐			
Open Heart Surgery	☐	☐			

Previous Operations/Procedures:	Year	Surgeon	Place (Hospital or City)	Complications/Problems

Reasons for other Hospitalizations (Non-Surgical Admissions)	Year	Physician	Place (Hospital or City)

Please List Any Other Medical Illnesses, Any Other History of Cancer or Chronic Conditions	How Long Have You Had This

If you are scheduled for surgery or a hospital stay, please answer the following question:

Have you or a blood relative had any problems with anesthesia: ☐ Yes ☐ No

If yes, please describe: _____

Review of Systems

SKIN
- ☐ Rashes, psoriasis or dermatitis
- ☐ Non-healing sores or skin ulcerations

EYES
- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Permanent blindness in either eye
- ☐ Cataracts
- ☐ Glaucoma

HEART
- ☐ Heart attack, What year (s):_____
- ☐ Chest discomfort/angina with physical activity
- ☐ Chest discomfort/angina at rest
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath at rest
- ☐ Require more than one pillow at night to breathe well
- ☐ Heart failure or "fluid on lungs"
- ☐ Palpitations, racing or pounding heart beat
- ☐ Pauses in the heart beat
- ☐ Previously diagnosed heart rhythm disturbance
- ☐ Heart murmur
- ☐ Mitral valve prolapse

BLOOD
- ☐ Bleeding or bruising tendency
- ☐ Blood disorder
  Specify: _____
- ☐ Previous blood transfusion
- ☐ Recent fever
- ☐ History of hepatitis or other communicable disease

STOMACH/INTESTINES
- ☐ Stomach ulcer or peptic ulcer
- ☐ Frequent heartburn or indigestion
- ☐ Liver disease or jaundice
  What year: _____
- ☐ Frequent diarrhea
- ☐ Chronic constipation
- ☐ Dark, tarry stools

EAR/NOSE/THROAT
- ☐ Loss of hearing
  Hearing Aids? ☐ Yes ☐ No
- ☐ Ringing in the ears
- ☐ Frequent or severe nose bleeds
- ☐ Frequent sinus infections
- ☐ Dentures

NERVOUS SYSTEM
- ☐ Frequent headaches or migraines
- ☐ Epilepsy or seizures
  Date of last seizure: _____
- ☐ Depression
- ☐ Nervous disorder
  Specify: _____

CIRCULATION
- ☐ Discoloration of feet or legs
- ☐ Pain in legs or buttocks with exercise
- ☐ Sores or ulcers on feet or legs
- ☐ Blood clot in artery
- ☐ Blood clot in leg vein
- ☐ Ankle or leg swelling
- ☐ Phlebitis of leg veins
- ☐ Sudden visual disturbances in either eye
- ☐ Weakness or paralysis of one side of the body
- ☐ Temporary speech loss or difficulty talking
- ☐ Stroke
- ☐ Dizziness, light-headedness or "black out spells"
- ☐ Aneurysm of any blood vessels
- ☐ "Mini-strokes" or TIA's

LUNGS
- ☐ Asthma or wheezing
- ☐ Recent bronchitis or chest cold
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Exposure to asbestos
- ☐ Blood clot (embolus) to lungs

KIDNEYS/URINARY TRACT
- ☐ Kidney disease or failure
- ☐ History of kidney dialysis
  What year: _____
- ☐ Kidney stones or infection
- ☐ Pain or burning with urination
- ☐ Dribbling or incontinence
- ☐ Multiple trips to bathroom to urinate at night
- ☐ Blood in urine during past year
- ☐ Enlarged prostate

METABOLISM/ENDOCRINE
- ☐ Thyroid disorder
- ☐ Gout
- ☐ Recent weight gain or loss (> 10 lbs)

MUSCLES/BONES/JOINTS
- ☐ Arthritis or other joint disease
- ☐ Chronic back trouble
- ☐ Curvature of the spine (scoliosis)

REPRODUCTIVE (for Women)
Are you or might you be pregnant?

☐ Yes ☐ No

Date (or year) of last period: _____

REPRODUCTIVE (for Men)
Have you had a vasectomy?

☐ Yes ☐ No

Erectile Dysfunction?

☐ Yes ☐ No

Family History

Relation	Age	Age at Death	Cardiac History
Father:			
Mother:			
Sister:			
Sister:			
Brother:			
Brother:			

Please list which family members (blood relatives) have experienced these conditions

Heart Attack: _____ Age: _____
_____ Age: _____
_____ Age: _____
Sudden Death: _____ Age: _____
_____ Age: _____
_____ Age: _____
Stroke: _____ Age: _____
_____ Age: _____

Aneurysm: _____
Diabetes: _____
Cancer: _____
High Blood Pressure: _____
High Cholesterol: _____
Heart Failure: _____
Arteriosclerosis: _____
(hardening of the arteries)

Do you have any other special concerns or additional information we should be aware of regarding your care:

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient signature **Date**