Mobile Heart Specialists, P.C.

Medical History Form

Patient Name____ **Account#**______________________

Date of Birth_____________________ **Referring Physician**____

History/Chief Complaint (Describe major symptoms) ____

Patient History:

			Diagnosis Date				Diagnosis Date
Coronary Artery Disease	No	Yes	________________	High Cholesterol	No	Yes	________________
Heart Attack	No	Yes	________________	Glaucoma	No	Yes	________________
Congestive Heart Failure	No	Yes	________________	Asthma/Emphysema	No	Yes	________________
Diabetes	No	Yes	________________	High Blood Pressure	No	Yes	________________
Thyroid disease	No	Yes	________________	Anemia	No	Yes	________________
Cancer	No	Yes	________________	Stroke	No	Yes	________________
Migraines	No	Yes	________________	Ulcers	No	Yes	________________
Heart Murmur	No	Yes	________________	Colitis	No	Yes	________________
Arthritis/Gout	No	Yes	________________	Convulsions/Seizures	No	Yes	________________
Hepatitis	No	Yes	________________	Kidney disease	No	Yes	________________
Bleeding tendency	No	Yes	________________	HIV (AIDS)	No	Yes	________________
Rheumatic Fever	No	Yes	________________	Heart rhythm problems	No	Yes	________________
Mental illness	No	Yes	________________	Other Medical illness	No	Yes	________________

Allergies/Medication Intolerance:

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Allergic to Iodine, Shellfish, or x-ray dye: No Yes

Family Medical History:

	Age	Disease/Illness	If deceased, cause of death
Father	_____	__________________	____
Mother	_____	__________________	____
Siblings	_____	__________________	____
____________	_____	__________________	____
____________	_____	__________________	____

Patient Social History:

Marital Status:	Single_____	Married_____	Divorced_____	Widowed_____
Use of Alcohol:	Never_____	Rarely_____	Moderate_____	Daily______
Use of Tobacco:	Never_____	Previously, but quit______ When_____	Current packs/day_____	
Drug Use:	Never_____	Frequency___________	Type_______________	
Caffeine Use:	No_____	Yes_____	Number of cups/day_____	
Exercise:	Never_____	Occasionally_____	Moderately_____	Daily_____

PRIOR CARDIAC PROCEDURES	Yes	No	When	Where
Angioplasty/Stent(s)				
Bypass surgery				
Pacemaker				
Defibrillator				
Ablation				
Heart Catheterization				

Check if you have had any of the following symptoms in the last six (6) months

CARDIOVASCULAR	Yes	No	Comments
Chest pain/pressure			
Pain in legs with walking			
Swelling in feet			
Fast heart rate			
Shortness of breath at night			

GENERAL	Yes	No	Comments
Changes in sleep patterns			
Decrease in activity level			
Fatigue			

SKIN	Yes	No	Comments
Bruising			

EYES	Yes	No	Comments
Vision changes			

HENT	Yes	No	Comments
Unusual headaches			
Nosebleeds			

GASTROINTESTINAL	Yes	No	Comments
Nausea			
Difficulty swallowing			
Heartburn			
Constipation			
Diarrhea			
Vomiting			
Blood in stools(black tarry stools)			

MUSCULOSKELETAL	Yes	No	Comments
Muscle pain			
Joint pain			
Joint swelling, deformity			
Numbness			

RESPIRATORY	Yes	No	Comments
Difficulty breathing			
Short of breath with walking			
Cough			
Wheezing			

NEUROLOGICAL	Yes	No	Comments
Loss of consciousness/fainting			
Seizures			
Weakness			
Memory Loss			

PHYSCHIATRIC	Yes	No	Comments
Family/Work Stress			
Anxiety			
Depression			

GENITOURINARY	Yes	No	Comments
Problems with urination			
Lack of bladder control			
Erectile Dysfunction			

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Surgeries:(list)

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