marinhealth Medical Network | UCSF Health

CARDIOVASCULAR MEDICINE

PATIENT HISTORY FORM

Name: _____ DOB: _____ Today's Date: _____

Reason for Visit: _____

Occupation: _____ Marital Status: _____

MEDICAL PROBLEMS: Please check all that apply.

____ Hypertension
____ Diabetes Mellitus
____ High Cholesterol
____ Hepatitis
____ Lung Disease
____ Thyroid Disease
____ Kidney Disease
____ Neurologic Disorders
____ Stomach/Bowel Disorders
____ Bleeding Tendencies
____ Other: _____
____ Other: _____

VASCULAR SYMPTOMS: Please check all that apply.

____ Leg Pain at Rest
____ Abdominal Pain
____ Arm or Facial Swelling
____ Arm or Facial Numbness
____ Arm or Foot Tingling
____ Non-healing Wound
____ Leg Swelling
____ Double Vision
____ Loss of Speech
____ Swallowing Difficulty
____ Dizziness
____ Leg Pain while Walking
____ Varicose Veins
____ Leg Infection
____ Other: _____

How far can you walk? _____ Can you climb two flights of stairs? _____ R or L Handed? _____

OTHER SYMPTOMS: Please check all that apply.

____ Shortness of Breath
____ Fainting Spells
____ Dizzy Spells
____ Trouble Breathing Lying Flat
____ Chest Pain or Discomfort
____ Awaking from Sleep Gasping for Air
____ Fluid Retention
____ Palpitations
____ Other: _____

HEALTH HABITS: Please check all that apply.

____ Alcohol: ____ drink(s) per day ____ Coffee (caffeine): ____ cup(s) per day

____ Smoking: ____ pack(s) per day, for ____ years. If stopped, when: _____

Exercise: ____ None ____ Occasional ____ Regular ____ Other: _____

MEDICATIONS: Please include strength and frequency. Include herbs and supplements.

Medication	Dose/Strength	Frequency

ALLERGIES

Medications: 1) _____ 2) _____ 3) _____

Environmental: _____

OTHER ISSUES YOU WOULD LIKE TO ADDRESS: _____

_____

PREVIOUS HOSPITALIZATIONS AND SURGERIES

Reason	Date	Where

FAMILY HISTORY

	Age	Health Problems	If Deceased, Cause	Age at Death
Mother				
Father				
Brothers/Sisters				
Children				

REVIEW OF SYSTEMS (Please check)

Constitutional	____ Change in Weight	____ Weight Loss	____ Change in Hair
	____ Difficulty Sleeping	____ Cold/Heat Intolerance	____ Fevers
	____ Sweats	____ Chills	____ Fatigue
HEENT	____ Loss of Eyesight	____ Wear Glasses	____ Hearing Loss
	____ Headache	____ Ear Infection	____ Sinus Infection
	____ Mouth Sores	____ Difficulty Swallowing	
Gastrointestinal	____ Stomach Pain	____ Diarrhea	____ Constipation
	____ Change in Bowels	____ Nausea	____ Vomiting
	____ Black Stools	____ Bloody Stools	____ Vomiting Blood
	____ Ulcers	____ Polyps	____ Heartburn
Urologic	____ Blood in Urine	____ Burning w/Urination	____ Urination at Night
	____ Impotence or Kidney Stones	____ Recurrent Urine Infection	
Musculoskeletal	____ Weakness	____ Joint Pains	____ Muscle Aches
	____ Back Pain		
Neurologic	____ Tremor	____ Difficulty Speaking	____ Numbness
Endocrine	____ Thyroid Disease	____ Menopausal Symptoms	
Respiratory	____ Cough	____ Coughing Up Blood	____ Wheezing
Hematologic	____ Bleeding Tendencies	____ Blood Clots in Lungs	____ Blood Clots in Legs
	____ Cancer Type		
Skin	____ Rash	____ Itching	____ Change in Skin
Mental Status	____ Depression	____ Anxiety	____ Panic Attacks