Coastal Healthcare

Name: _____ Date of Birth: _____

Reason for your visit today: _____

Which physician requesting consult? _____

Primary care physician? _____

PAST MEDICAL HISTORY Please list your past/present medical problems:

SURGICAL HISTORY: Please list all past surgeries:

Procedure	Date	Procedure	Date

CARDIAC TESTING: Please list all previous cardiac testing you may have had:

Test Name	Date	Test Name	Date

ALLERGIES:

Drug Name	Reaction	Drug Name	Reaction

Date of your Last Flu Shot: _____ **Date of your last Pneumonia Vaccine: _____**

Vitals: (for office use only)

Height: _____ Weight: _____ Pulse: _____ SpO2: _____ BP: _____ Temp: _____

Name: _____ Date of Birth: _____

SOCIAL HISTORY: Please answer all questions in bold

Family History of Heart Disease?	YES	NO	**Comment:**			
Smoking Status	Never	Former	Current Daily	Current sometimes	**If you have quit, when did you quit?**	
How much do you smoke per day?				**What age did you start smoking?**		
Do you chew tobacco?	YES	NO		**Are you Diabetic?**	YES	NO
Alcohol intake	None	Occ	Mod	Heavy	**If you have quit, when did you quit drinking?**	
Do you use or have you used illicit drugs?	YES	NO	**Type of Drug used: SPECIFY IF CURRENT or PAST USE**			
Exercise Level	None	Occ	Mod	Heavy	**Occupation?**	

FAMILY HISTORY: Has anyone in your family (blood related) ever had any of the following?
Specify if Maternal or Paternal

Heart Disease

Relation:	Type:

Stroke

Relation:	Type:

Cancer

Relation:	Type:

Diabetes

Relation:	Type:

MEDICATIONS

Pharmacy Name: _____

Medication Name	Dosage

Medication Name	Dosage

Name: _____ DOB: _____

REVIEW OF SYSTEMS

Please check if you are currently having or have had a history of the following:

CONSTITUTIONAL

____ Excess Weight Loss
____ Excess Weight Gain
____ Fever
____ Exercise Intolerance
____ Night Sweats

ENT and EYES

____ Sore Throat
____ Snoring
____ Sinus Problems
____ Hearing Loss
____ Ear Pain
____ Nose Bleeding
____ Vision Changes
____ Dry Eyes

CARDIOVASCULAR

____ Chest Pain
____ Arm Pain w/exertion
____ Shortness of breath w/walking
____ Shortness of breath w/lying down
____ Palpitations
____ Heart Murmur

RESPIRATORY

____ Cough
____ Wheezing
____ Shortness of Breath
____ Coughing up Blood

GASTROINTESTINAL

____ Change in Appetite
____ Heartburn
____ Nausea
____ Vomiting
____ Constipation
____ Diarrhea
____ Blood in Stool
____ Abdominal Pain
____ Ulcers

GENITOURINARY

____ Incontinence
____ Blood in Urine
____ Frequency
____ Difficulty Urinating

MUSCULOSKELETAL

____ Swelling in Extremities
____ Back Pain
____ Joint Pain
____ Muscle Weakness
____ Muscle Aches

SKIN

____ Rashes
____ Abnormal Moles
____ Itching
____ Dry Skin
____ Jaundice

NEUROLOGICAL

____ Fainting
____ Muscle Weakness
____ Numbness
____ Headaches
____ Stroke
____ Dizziness
____ Seizures

PSYCHIATRIC

____ Depression
____ Sleep Disturbance
____ Feel Unsafe
____ Alcohol Abuse
____ Anxiety

ENDOCRINE

____ Fatigue

HEMATOLOGIC

____ Bruise Easily
____ Swollen Glands
____ History of Blood Clots

ALLERGIC

____ Runny Nose
____ Sinus Pressure
____ Itching
____ Hives
____ Frequent Sneezing

OTHER: (please list)

____ Steroid Use
____ Asthma
____ Heart Attack
____ High Blood Pressure
____ Thyroid Disease
____ Anemia

_____

_____

_____

_____