CARDIAC SURGERY
NEW PATIENT HEALTH HISTORY

Date of Visit: __________________ **Account Number:** ___________________
Last Name: __________________ **First Name:** ________________ **MI:** ______
Date of Birth: ____________ **Age:** _____ **Sex:** **M/F** **SS#:** _____________
Primary Care Physician: ___________ **Requesting Physician:** ____________
Reason for Office Visit Today: ____

HISTORY OF PRESENT ILLNESS

____
____
____
____
____
____
____
____
____
____

PAST MEDICAL HISTORY: (i.e. diabetes, high blood pressure…)

Diagnosis	Year Diagnosed
1. ________________________________	______________
2. ________________________________	______________
3. ________________________________	______________
4. ________________________________	______________
5. ________________________________	______________
6. ________________________________	______________
7. ________________________________	______________
8. ________________________________	______________
9. ________________________________	______________

Patient Name:___________________________________

Do you have any of the following already prepared?

☐ Yes ☐ No Advance Directives (Living Will)
☐ Yes ☐ No Durable Power of Attorney for Health Care
☐ Yes ☐ No Organ Donation
☐ Yes ☐ No Mental Health Directive

PAST SURGICAL HISTORY:

Please list any previous surgeries/procedures and approximate year below.

Surgical Procedure	**Year**
1. ______________________________	__________
2. ______________________________	__________
3. ______________________________	__________
4. ______________________________	__________
5. ______________________________	__________
6. ______________________________	__________
7. ______________________________	__________
8. ______________________________	__________
9. ______________________________	__________

Have you ever been hospitalized for any reason besides surgery? ☐ Yes ☐ No
If yes, reason and date: ______________________________

Do you have any physical limitations? ☐ Yes ☐ No
If yes, please explain: ______________________________

Have you ever had a blood transfusion: ☐ Yes ☐ No
If yes, when? ____________________ Adverse reaction? ☐ Yes ☐ No

Do you consent to the use of blood or blood products if necessary? ☐ Yes ☐ No
If no, please list religious or personal reason ________________

Patient Name:___________________________________

ALLERGIES:

Please list all medications to which you have an allergy or an adverse response and the corresponding reaction

Medication	Reaction	Medication	Reaction

CURRENT MEDICATIONS:

Please list all medications (prescription and non-prescription), including vitamins, aspirin, herbs and/or appetite suppressants.

Name	Dose	Frequency	Name	Dose	Frequency

Patient Name:______________________________________

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Number of children: ______________________________

Current hometown: ______________________________

With whom do you live?______________________________

Who is at home to take care of you following surgery, or will you be residing elsewhere?
Please explain: ______________________________

Current (or previous) occupation: ______________________
Are you retired? ☐ Yes ☐ No

How stressful is your job? ☐ None ☐ Mildly ☐ Moderately ☐ Very

List any hobbies: ______________________________________

Do you exercise? ☐ Yes ☐ No
If yes, describe how and how often: ______________________

Do you smoke? ☐ Yes ☐ No, but used to ☐ Never smoked
How many packs of cigarettes do/did you smoke per day? __________
How many years have you smoked?________________________
When did you quit? ________________________________

Do you drink alcohol? ☐ Yes ☐ No, but used to ☐ Never drank
How much of the following did/do you drink in an average week?
_____ glasses of wine ______ beers ______drinks
When did you quit? ____________________

Do you consume caffeine? ☐ Yes ☐ No, but used to ☐ Never
When did you quit? ______________________________
How much in an average day do you consume of the following:
______ Sodas ______ Cups of Coffee ______ Glasses of Tea

Do you take illicit drugs or abuse prescription medications? ☐ Yes ☐ No, but used to ☐ Never
If yes, please specify: ______________________________________

Patient Name:______________________________________

FAMILY HISTORY

Please place an “X” in any boxes that apply.

ILLNESS	FATHER	MOTHER	BROTHER	SISTER	GRAND FATHER	GRAND MOTHER	SON/S	DAUGHTER/S
LIVING	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Age								
High blood pressure								
High cholesterol								
Diabetes								
Heart attack before age 50								
Heart attack after age 50								
Other Heart Disease								
Blood or clotting disorder								
Stroke before age 50								
Stroke after age 50								
Lung cancer								
Esophageal cancer								
Breast cancer								
Other cancer								
Sudden Death								

Patient Name:___________________________________

REVIEW OF SYSTEMS

Please check all that apply and indicate the date the condition started.

I. Cardiovascular System Review

		Condition	Date
☐ Yes	☐ No	diabetes (insulin dependent ☐ Yes ☐ No)	__________
☐ Yes	☐ No	high blood pressure	__________
☐ Yes	☐ No	high cholesterol	__________
☐ Yes	☐ No	history of weight loss medicine (i.e. phen/fen)	__________
☐ Yes	☐ No	rheumatic/scarlet fever	__________
☐ Yes	☐ No	heart murmur	__________
☐ Yes	☐ No	chest pain or pressure when I exert myself	__________
☐ Yes	☐ No	chest pain or pressure at rest	__________
☐ Yes	☐ No	chest pain or pressure awakens me at night	__________
☐ Yes	☐ No	shortness of breath upon exertion	__________
☐ Yes	☐ No	shortness of breath at rest	__________
☐ Yes	☐ No	I awaken at night with shortness of breath	__________
☐ Yes	☐ No	coronary artery disease	__________
☐ Yes	☐ No	abnormal EKG	__________
☐ Yes	☐ No	heart attack	__________
☐ Yes	☐ No	congenital heart disease	__________
☐ Yes	☐ No	arrhythmia (abnormal heart rhythm)	__________
☐ Yes	☐ No	heart failure	__________
☐ Yes	☐ No	abnormal heart valve	__________
☐ Yes	☐ No	mitral valve prolapse	__________
☐ Yes	☐ No	hospitalized for cardiac reasons	__________
☐ Yes	☐ No	any other type of heart disease	__________

II. Previous Cardiovascular Testing:

☐ Yes	☐ No	stress test	date ______	location ______________
☐ Yes	☐ No	echocardiogram	date ______	location ______________
☐ Yes	☐ No	nuclear study	date ______	location ______________
☐ Yes	☐ No	holter	date ______	location ______________
☐ Yes	☐ No	carotid ultrasound	date ______	location ______________
☐ Yes	☐ No	catheterization/angiogram	date ______	location ______________
☐ Yes	☐ No	electrophysiology study	date ______	location ______________
☐ Yes	☐ No	CT angiogram	date ______	location ______________

Patient Name:______________________________________

III. Vascular System Review

☐ Yes ☐ No carotid artery disease ______________
☐ Yes ☐ No renal artery disease ______________
☐ Yes ☐ No peripheral artery disease (poor leg circulation) ______________
☐ Yes ☐ No history of aneurysm ______________
☐ Yes ☐ No claudication (cramping in legs while walking) ______________
☐ Yes ☐ No phlebitis (clots in legs) ______________
☐ Yes ☐ No pulmonary embolism (clots in lungs) ______________
☐ Yes ☐ No any other type of vascular disease ______________

IV. Lung System Review

☐ Yes ☐ No chronic cough _____________
☐ Yes ☐ No new cough _____________
☐ Yes ☐ No sputum production _____________
☐ Yes ☐ No hemoptysis (coughing blood) _____________
☐ Yes ☐ No hoarseness
☐ Yes ☐ No asthma _____________
☐ Yes ☐ No wheezing _____________
☐ Yes ☐ No shortness of breath at rest _____________
☐ Yes ☐ No shortness of breath with activity _____________
☐ Yes ☐ No bronchitis _____________
☐ Yes ☐ No pneumonia _____________
☐ Yes ☐ No sleep apnea _____________
☐ Yes ☐ No snoring _____________
☐ Yes ☐ No tuberculosis _____________

V. Previous Pulmonary Testing

☐ Yes ☐ No chest x-ray date ______ location _____________
☐ Yes ☐ No CT scan date ______ location _____________
☐ Yes ☐ No PET scan date ______ location _____________
☐ Yes ☐ No needle biopsy date ______ location _____________
☐ Yes ☐ No pulmonary function tests date ______ location _____________
☐ Yes ☐ No bronchoscopy date ______ location _____________
☐ Yes ☐ No tissue biopsy date ______ location _____________

Patient Name:______________________________________

THE FOLLOWING QUESTIONS RELATE TO HEALTH PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST.
(Please circle the appropriate conditions)

☐ Yes	☐ No	**endocrine/hormonal** (thyroid disease, adrenal disease, goiter)
☐ Yes	☐ No	**neurological** (seizures, vertigo, previous stroke, aneurysm, etc…)
☐ Yes	☐ No	**ophthalmologic** (glaucoma, cataracts, visual impairment, etc…)
☐ Yes	☐ No	**ears, nose, throat** (snoring, hearing aids, sinus, hoarseness, nose bleeds, etc…)
☐ Yes	☐ No	**gastrointestinal** (hiatal hernia, reflux esophagitis, esophageal disease ulcers, gastritis, hepatitis, yellow jaundice, other liver disease, gallstones, gallbladder disease, pancreatic disease, chronic constipation or diarrhea, diverticulosis, diverticulitis, GI bleeding, Crohn's, ulcerative colitis, irritable bowel, other intestinal disease)
☐ Yes	☐ No	**renal/kidney** (renal insufficiency, dialysis, kidney stones, etc…)
☐ Yes	☐ No	**urological** (prostate disease, frequent bladder infections, impotence, etc…)
☐ Yes	☐ No	**immunological** (gout, rheumatoid arthritis, lupus, etc…)
☐ Yes	☐ No	**infectious** (aids, hepatitis, TB, syphilis, endocarditis, etc…)
☐ Yes	☐ No	**hematologic** (anemia, bleeding problem, clotting problem, leukemia, etc…)
☐ Yes	☐ No	**psychological** (depression, anxiety, panic attacks, anorexia, bulimia, etc…)
☐ Yes	☐ No	**physical disability** (problems with walking, etc…)
☐ Yes	☐ No	**skin** (psoriasis, eczema, petechiae, etc…)
☐ Yes	☐ No	**vascular** (varicose veins, aortic aneurysm, etc…)
☐ Yes	☐ No	**musculoskeletal** (joint pain, arthritis, weakness, etc…)
☐ Yes	☐ No	**miscellaneous** (osteoporosis, congenital syndrome, Marfan's, Turner's, etc…)

I have reviewed the above information with the patient:
______________________________________ **(RN/PA/ACNP)**
______________________________________ **(M.D.)** _________ **Date**

Revised 2.1.10