PULSE
HEART | VALVE | VASCULAR

Have you ever had the following?

Arthritis	Yes	No	Dysrhythmia	Yes	No	Rheumatic Fever (	Yes	No
Atrial Fibrillation	Yes	No	Heart Attack/Myocardial Infarction	Yes	No	Sleep Apnea	Yes	No
Bleeding Problems	Yes	No	Heart Failure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Thyroid Disease (	Yes	No
Cardiomyopathy	Yes	No	Hiatal Hernia (	Yes	No	Tuberculosis (	Yes	No
Carotid Artery Disease	Yes	No	Hypertension	Yes	No	Ulcers (Whooping	Yes	No
V RUR U(T UHU(W LVz VH	Yes	No	High Cholesterol	Yes	No	Cough	Yes	No
V h i W	Yes	No	Kidney Disease	Yes	No			
W lz EHWH(f HOOXOV	Yes	No	i HUSHz O o z VFX U(W LVz VH	Yes	No			
DVT	Yes	No						

Have you had any other medical problems diagnosed that we have not asked about? _____ (

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Have you had any of the following medical services?

Holter Monitor	Yes	No	Angioplasty or Stent	Yes	No	**Allergies:** _____
Stress Test	Yes	No	CABG (Coronary Artery Bypass Surgery)	Yes	No	_____
Echocardiogram	Yes	No	Pacemaker Insertion	Yes	No	_____
Cardiac Catheterization	Yes	No	ICD (Defibrillator Insertion)	Yes	No	_____

Surgeries or Hospitalizations Not Listed Above

_____ (

_____ (

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Local Anesthetic	No	Yes
X-ray Dye or Iodine	No	Yes
Shellfish	No	Yes

Family History

Check All That Apply

Relationship	Status	Diabetes	Hypertension	Heart Disease	Anemia	Arrhythmia	Asthma	Clotting Disorder	CVA (Stroke)	Heart Attack	Heart Failure	High Cholesterol
Mother												
Father												
Sister												
Brother												

Social History

n FRRR/ VH HU HHN/ w HD/ rU/ VH/ /p UH / /w / H SV

/ //u DXV R/ LH

/ /p DV R/ o HU

/ I KRW R(e LXRU

xxx(W ULCN(V RZ/LQ(C A H (R(R(T ORRRQ 2 f LHG W ULCN3

V zIIHLQ n VH Yes / No

V XS(SHU(W z /p S Y HUrD

mRz FRR n VH HV / R// HVU

g XEHU(R(r hz LV _____ (r hz LV(((j XLV W z VHM (xxxxx(i z FN(SHU(W z (_____

I FNHOPW(mRz FRR _____ /

Review of Systems

Have you experienced any of the following in the **past two months**?

Constitutional

Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes
Cataracts	No	Yes

ENT

Hearing loss	No	Yes
Sinus pain	No	Yes
Nose bleeds	No	Yes

Cardiovascular

Chest pains	No	Yes
Sudden heart beat changes or palpitations	No	Yes
Swelling of feet, ankles or hands	No	Yes

Respiratory

Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath at rest	No	Yes
Shortness of breath with activity	No	Yes
Shortness of breath while lying flat	No	Yes
Asthma or wheezing	No	Yes
Wake up at night smothering	No	Yes
Snore while sleeping	No	Yes
Excessive day time sleepiness	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes
	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney stones	No	Yes
Wake up at night to urinate	No	Yes

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back problems	No	Yes
Cold extremities	No	Yes
Difficulty walking	No	Yes
Pain in legs when you walk	No	Yes

Skin

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes

Neurological

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Fainting episodes	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness or anxiety	No	Yes
Depression	No	Yes

Endocrine

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

Do you having any other medical concerns?

_____

_____

_____

_____

Patient signature: _____ Date: _____