Smart Heart Care
Keshav Chander, MD RVT
Cardiologist
Smart Medical Care
Renu Mahajan, MD
Internist

Patient Health History

This questionnaire will become a confidential part of your medical record. If you do not want to answer a question, leave it blank and discuss it privately with your doctor at your visit.

Name: _____ Date of Birth: _____
Last First Middle

Today's date: _____ Primary Care Physician:_____

Name of physician recommending today's visit:_____

What are the main reasons for this visit?
1. _____ 3. _____
2. _____ 4. _____

Medical History

Check major, significant illnesses, which apply to you:

- □ Anemia
- □ Asthma
- □ Arthritis
- □ Bleeding/ Blood Disorder
- □ Breast Cancer
- □ Cancer (s) _____
- □ Diabetes, Adult Onset
- □ Diabetes, Juvenile Onset
- □ Emphysema
- □ Glaucoma
- □ Heart Problems
  - □ Irregular Heartbeat
  - □ History of Artery Blockages
  - □ History of Valve Problems
  - □ History of Bypass
- □ History of Stents
  - □ History of Heart Attack
  - □ Other:_____
- □ High Blood Pressure
- □ High Cholesterol
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Rheumatic Fever
- □ Stroke
- □ Thyroid Disease
- □ Ulcers
- □ Hepatitis/ Jaundice
- □ HIV/ AIDS
- □ Others:_____

Medications

List all medications you are currently taking including all over-the-counter drugs:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Check Any Allergies

□ Medications List/ Describe:_____
□ Food □ Animals □ Latex □ Tape □ Pollens □ Iodine
□ Other:_____

Surgical/Hospital

Check any operations/ procedures you have had:

□ Heart Catherization/ Surgery □ Pacemaker Insertion Other:_____

What other doctors have you seen?_____

Family History

Are you adopted? □ Yes □ No

Was any of your family members found to have blocked arteries

Female (before the age of 65) □ Yes □ No

Male (before the age of 55) □ Yes □ No

Social History

1. Occupation:_____ 2. Gender: □ Male □ Female

3. Tobacco use? □ Never □ Past □ Current
   a. Indicate type: □ Chew/Smokeless □ Cigar □ Pipe □ Cigarette □ Other_____
   b. Indicate average number of packs used per day:_____
   c. Number of years tobacco used:_____ d. Year quit:_____

4. On average, how many alcoholic drinks do you consume during one day (1 drink= 12oz beer, 10oz wine cooler, 5oz wine, or 1.5oz Liquor)?
   □ Non-drinker OR
   - How many days a week do you drink? □ < 1 □ 1 - 2 □ 3 - 4 □ 5 - 7
   - How many do you consume at one time? □ 1 □ 2 □ 3 □ 4 or more

5. Do you follow a special diet?
   □ Low salt □ Diabetic □ Low fat/ Cholesterol □ Low calorie □ Vegetarian
   □ Other:_____

6. How many days per week do you exercise for at least 10 minutes? □ 0 □ 1-2 □ 3-5 □ 6-8
   □ Walking □ Running □ Weightlifting □ Biking/exercise machine □ Swimming
   □ Aerobics □ Organized sports □ Other:_____

Check any condition(s) which are <u>SIGNIFICANT PROBLEMS</u> to you:

General

□ Recent 10lb weight change
□ Fevers (frequent)
□ Frequent profound fatigue
□ Frequent difficulty sleeping
□ I have had a blood transfusion
□ Sexually transmitted diseases:_____

Head and Neck

□ Visual changes (not glasses)
□ Dizziness
□ Double vision
□ Sinus Problems
□ Frequent persistent nosebleeds
□ Ear pain
□ Trouble hearing

Reproduction

□ Blood in semen/ sperm (men)
□ Inability to have an erection (men)
□ Inability to reach climax
□ Infertility
□ Decreased sexual desire

Women

□ Breast pain/ lumps
□ Pelvic pain
□ Vaginal discharge
□ Frequent sweats/ hot flashes
□ Menstrual problems
Date of last period:_____

□ Ringing in the ear

Head and Neck (continued)
□ Hoarseness
□ Persistent sore throat
□ Mouth sores
□ Swollen glands (frequent)

Respiratory/ Lungs
□ Persistent cough
□ Shortness of breath
□ Coughing up blood
□ Wheezing
□ Stop breathing during sleep
□ Weakness in arms/ legs

Heart/ Vascular
□ Chest pain/ tightness
□ Irregular rapid heartbeat
□ Smothering feeling at night
□ Ankle swelling
□ Numbness or tingling

Stomach/ Bowel
□ Major appetite change
□ Nausea/ Vomiting (frequent)
□ Frequent heartburn/ acid in throat (GERD)
□ Abdominal pain
□ Diarrhea (frequent)
□ Constipation (frequent)
□ Black/ bloody stools
□ Vomiting blood
□ Difficulty swallowing
□ Major skin problems

Kidney/ Bladder
□ Kidney/ Bladder infection
□ Difficulty starting urination
□ Frequent urination
□ Increased urgency
□ Urination more than one nightly
□ Burning or painful urination
□ Blood in urine
□ Difficulty emptying bladder
□ Problem with bladder control
□ Marital or relationship problems

Anything Else?

_____

_____

_____

Number of miscarriage/ abortions_____

□ Menopause

Women (continued)
□ Pregnancy problems
□ Baby weighing 9lbs or more
Number of full term births (>36wks)_____
Number of premature births (<36wks)_____

Number of living children_____

Skeletal
□ Joint pain (major)
□ Back pain (major)
□ Neck pain (major)

□ Joint swelling/ stiffness
□ Deformities of the back/ extremities
□ Gout

Neurological

□ Severe frequent headaches
□ Abnormal coordination
□ Trouble with speech
□ Forgetfulness/ confusion

Skin and Hair Problems
□ Changes in hair/ hair loss (major)
□ Wounds that will not heal
□ Persistent rash
□ Changes in moles

Psychological/ Social
□ Feeling blue/ discouraged
□ High anxiety/ stress
□ Loss of friends
□ Feeling life has no purpose
□ Feeling fear
□ Hearing voices
□ Feeling others talking about you
□ Early morning awakenings