Cenla Heart Specialists
PERSONAL HISTORY

To be completed by the Patient and brought to first Physician's appointment.
Please use ink or typewriter. DO NOT USE PENCIL

DATE ______________________________

Name ______________________________ Clinic No. (if any) ______________

Address ______________________________

Age ________ Sex ________ Occupation ______________ Descent (Race or Nationality) ______________

Were you referred by a physician for this visit? ________ Do you wish a medical report sent to your physician? ________

Do you have a regular doctor or nurse who takes care of your medical problems?

Name ______________ Address ______________ Phone ______________

Name ______________ Address ______________ Phone ______________

Please state briefly the main problem which prompted you to consult us, and the length of time you have had it.

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I. PAST MEDICAL HISTORY

HAVE YOU HAD:	No	Yes	Year	HAVE YOU HAD:	No	Yes	Year	HAVE YOU HAD:	No	Yes	Year
Measels (Rubeola)				Heart Disease or Murmur				Hay Fever			
German Measels (Rubella)				High Blood Pressure				Hives			
Mumps				Vein Trouble				Skin Disorder			
Rheumatic Fever				Blood Disease or Anemia				Eating Disorder (Anorexia Nervosa, Bulimia)			
Diphtheria				Bleeding Tendency							
Chicken Pox				Kidney Disease				Peptic Ulcer			
Tuberculosis (or positive TB skin test)				Kidney or Bladder Infection				Ulcerative Colitis			
				Bladder problems				Liver Disease			
Pneumonia or Pleurisy				Kidney Stones				Jaundice or Hepatitis			
Malaria				Prostate Trouble				Gallbladder Disease			
Amoebic Infection				Arthritis or Joint Trouble				Colon Polyp			
Intestinal Worms				Back Trouble				Hemorrhoids			
Syphilis				Ruptured Disc or Sciatica				Diabetes			
Gonorrhea				Gout				Goiter or Thyroid Trouble			
Polio				Asthma				Other Glandular Trouble			
Cancer				Chronic Bronchial Trouble				HIV +			
Radiation Treatment				Lung Disease				Hearing Impairment			
Organ Transplant				Epilepsy				Visual Impairment			
Nervous Disorder				Stroke or Paralysis							

Any illness or disease not included in above. ______________________________

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List Surgeries:	List Serious Accidents or Injuries:

Please bring your prescription medications with you to your appointment.
Please disclose to your physician all medications that are used regularly, because of the potential for dangerous interactions.

List Medications

Medication	Dose	Frequency	Medication	Dose	Frequency

List Allergies (Medication, Food or Environment)

____

____

IMMUNIZATIONS (please give date of last booster) Tetanus__________ Pneumovax__________ Influenza__________

Polio__________ (German Measles)__________ Diphtheria__________ (Measles)__________

Other____

Residence or travel outside USA (places and dates)______________________________

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II. MARITAL HISTORY

Presently Married? ____________ Years ______________ Previous marriages and duration ______________________

Health of Spouse ____

Children (if adoped, so state) ____________ No. living ______________ Sex, Ages & Health ______________

______________________ No dead ______________ Sex, Ages & Causes ______________

III. FAMILY HISTORY (blood relatives only)

			Living ?		Age, or Age at death	Present health or cause of death
			Yes	No		
FATHER:						
MOTHER:						
BROTHERS:	No. living	Write # in YES column				
	No. dead	Write # in NO column				
SISTERS:	No. living	Write # in YES column				
	No. dead	Write # in NO column				

Have any of your blood relatives ever had: (If yes, state relationship including aunt, uncle, grandparent, etc., and age.)

Cancer ______________ Heart Trouble ______________ Allergy ______________

Breast Cancer ______________ High blood pressure ______________ Bleeding tendency ______________

Colon Cancer ______________ Stroke ______________ Tuberculosis ______________

Colon Polyp ______________ Glaucoma ______________ Thyroid trouble ______________

Kidney disease ______________ Migraine (sick headache) ______________ Arthritis ______________

Peptic Ulcer ______________ Diabetes ______________ Nervous or mental disease ______________

IV. SOCIAL HISTORY

How many cups of coffee / tea / caffeine containing soft drinks do you regularly drink per day? ______________

Do you use tobacco now? __________ In the past? __________ For how long? __________ Type and amount daily: ______________

Do you drink alcoholic beverages? __________ How often do you drink? ______________ Have you or close family members been concerned about your drinking? ______________ Has drinking ever caused problems in your life? ______________

How much alcohol do you drink? (Circle average number of drinks per day) 0 1 2 3 4 5 6 more than 6

Have you or close family members been concerned about your use of non-prescription drugs? ☐ no ☐ yes

Has the use of non-prescription drugs ever caused a problem in your life? ☐ no ☐ yes

How many hours per week do you work? ______________ How often do you take a vacation? ______________

Do you get regular exercise? __________ What? ______________ How often? ______________

What hobbies do you have? ______________ Do you wear seat belts regularly? ______________

With what pets (or farm animals) have you recently had contact? ______________

Do you have any difficulty taking care of yourself? (bathing, dressing, meal preparation, etc.) ______________

Do you provide care in your home for someone who is disabled? __________ If yes, who? ______________

Do you have someone who can help you in an emergency? __________ If yes, who? ______________

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V. REVIEW OF SYSTEMS

HAVE YOU RECENTLY HAD:	YES	NO	M.D. COMMENTS
Weight change of more than 5 pounds (last six months)?			
Highest Adult Weight _________ *lbs.* *Age* _______			
Lowest Adult Weight _________ lbs. Age_______			
Unexplained fever, chills or night sweats?			
Unusual fatigue or lack of energy?			
Headaches?			
Light headedness, dizziness or vertigo?			
Fainting spells?			
Trouble with your vision other than needing glasses?			
Difficulty hearing?			
Difficulty hearing when someone whispers to you?			
Problems with your ears - ringing, buzzing, draining, itching or pain?			
A dental check-up?			
DO YOU HAVE:			
Trouble with snoring or sleep apnea?			
Stuffy nose, postnasal drip, sinus attack?			
Nosebleeds?			
Persistent or recurring hoarseness?			
Frequent sore throat?			
Major trouble with gums or teeth?			
Mouth or tongue problems - canker sores, burning tongue, etc?			
DO YOU HAVE:			
Trouble with your heart (including murmur)?			
Palpitations (thumping or racing of the heart)?			
Chest pain or chest discomfort?			
Trouble with your blood pressure?			
Problems with abnormal fluid retention or ankle swelling?			
Trouble with varicose veins or phlebitis?			
DO YOU:			
Regularly get pain in the legs when you walk any distance?			
Have frequent leg cramps at night (charley-horses)?			
Have fingers that become painful, numb, white or blue when they get cold?			
Have difficult or uncomfortable breathing?			
Become short of breath on activity or when excited?			
Have smothering episodes which awaken you at night?			
Sleep propped up in bed?			
Have wheezing or asthma?			
Have persistent or chronic cough?			
Bring up sputum, phlegm, or mucus from your chest?			
Have you ever coughed up blood?			
Are you on a special diet? (please check)			
_____ low calorie _____ low fat _____ low cholesterol _____ low salt			
_____ diabetic _____ vegetarian _____ other (please note) ______________			
Do you feel that your eating habits are unsound?			
Is there any type of food that disagrees with you? (please list)			
HAVE YOU RECENTLY HAD:			
Changes in your appetite?			
Trouble swallowing food or liquids?			
Heartburn, indigestion, gas or bloating?			
Nausea or vomiting?			
Abdominal pains or cramps?			

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	YES	NO	M.D. COMMENTS
Yellow jaundice or hepatitis?			
Changes in your bowel habits (last six months)?			
Trouble with constipation or diarrhea?			
Rectal pain or pain with bowel movements?			
Pale or clay colored stools?			
Stools with mucus?			
Hemorrhoids (piles), rectal itching or similar problems?			
HAVE YOU EVER:			
Vomited blood or material that looked like coffee grounds?			
Had black or tarry stools, or bright red blood in your stools?			
DO YOU:			
Use laxatives or enemas regularly?			
Have to wake up two or more times at night to urinate?			
Have difficulty in passing your urine?			
Have difficulty in holding your urine?			
Wear a pad for urinary leakage?			
HAVE YOU RECENTLY HAD:			
Pain or burning on urination?			
Blood in your urine?			
Kidney stone or colic, or passed gravel in your urine?			
Treatment for kidney or bladder infections?			
Treatment for prostate trouble?			
Any problem related to sexual function?			
Treatment for anemia?			
Unusual bleeding or bruising tendencies?			
Enlarged or painful glands?			
Unusual craving for sweets, salt or other foods?			
Excessive or unexplained thirst?			
A change in your capacity to tolerate hot or cold?			
Any skin disorders or places on your skin that concern you?			
Changes in your hair or nails that concern you?			
DO YOU:			
Tremble or shake abnormally?			
Have fits or convulsions?			
Have weakness or clumsiness of your arms or legs?			
Have any specific muscle weakness?			
Have numbness, tingling, burning or shooting pains in your arms or legs?			
Have joint swelling, pain or stiffness?			
Have any specific muscle weakness?			
Have recurring or severe backache?			
Have pain or stiffness in your neck?			
Have you ever had radiation (or x-ray) treatment (not routine x-rays)?			
DO YOU:			
Feel that you are tense or high strung?			
Feel your home or work is unpleasant?			
Have difficulty making up your mind?			
Have periods of depression or melancholy?			
Worry excessively?			
Become easily irritated or upset?			
Have persistent fears?			
Feel that nervous or emotional factors are important in your present illness?			
Have trouble sleeping?			
Are your feelings easily hurt?			
Have you ever consulted a psychiatrist, psychologist, social worker, or other therapist?			

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FOR WOMEN ONLY	YES	NO	M.D. COMMENTS
At what age did you start to menstruate? ________ years of age			
Are you still having menstrual periods?			
Are your periods regular?			
Do you bleed between your periods?			
How many days does your menstrual period usually last? _______ days			
Do you have problems with your periods (cramps, flooding, clots, etc.)?			
Do you have vaginal itching or discharge?			
When was your last period?			
How many pregnancies have you had?			
How many of these were miscarriages or stillborns?			
Was D & C done?			
Do you have any problems with your breasts other than at the time of your period?			

If there are any medical problems not covered in the previous questions that you would like to discuss, please note them in this space. Your physician will discuss them with you at your initial interview.

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VI. HEALTH CARE SCREENING

WHAT HEALTH CARE SCREENING HAVE YOU HAD?	No	Yes	Year	Physician Notes
Blood Pressure				
Cholesterol / HDL				
Hemoccult				
Flexible Sigmoidoscopy (or Colonoscopy)				
Eye Exam				
Digital Rectal Exam				
Females: Breast Exam Instruction				
Clinical Breast Exam				
Mammogram				
Pap/Pelvic Exam				
Males: Prostate Specific Antigen				

VII. COUNSELING NEEDS (please check)

Smoking ________ Nutrition ________ Sexually Transmitted Diseases ________ Dental Health ________

Exercise ________ Alcohol & Drug Use ________ Injury Prevention ________ Unintended pregnancy ________

Stress Management ________

REVIEWING PHYSICIAN ______________________________, **M.D.** **Date** ________________