



History and Physical Patient Form

Name:		
DOB:	Height:	Weight:
Reason for you visit:		
Referring Cardiologist:		
How did you hear about our office?		

Have you experienced any of the following?

CARDIOVASCULAR					
1. Irregular Heart Rate	Yes	No	15. Enlarged heart	Yes	No
2. Palpitations	Yes	No	16. Abnormal ECG	Yes	No
3. Dizziness or Lightheaded	Yes	No	17. Abnormal chest x-ray	Yes	No
4. Near fainting spells	Yes	No	18. Chest Injury	Yes	No
5. Fainting spells	Yes	No	19. Elevated cholesterol	Yes	No
6. History of Cardiac Arrest	Yes	No	20. Other lipid abnormal	Yes	No
7. Have you ever had a temporary pacemaker	Yes	No	21. Angina	Yes	No
			22. High blood pressure	Yes	No
8. Permanent Pacemaker	Yes	No	23. Low blood pressure	Yes	No
9. Chest Pain	Yes	No	24. Arteriosclerosis	Yes	No
10. Easily fatigued by exercise	Yes	No	25. Rheumatic fever	Yes	No
11. Ankle swelling	Yes	No	26. Congestive heart failure	Yes	No
12. Urinate after bedtime	Yes	No	27. Heart Attack	Yes	No
13. Sleep on more than 1 pillow	Yes	No	28. Any other heart conditions:	Yes	No
14. Aching in legs when walking	Yes	No			

RESPIRATORY					
1. Shortness of breath with:	Yes	No	5. Pneumonia	Yes	No
a. activity	Yes	No	If yes / date: _____		
b. minimal exertion	Yes	No	6. Blood clot to lung		
c. at rest	Yes	No	7. Respiratory diseases:	Yes	No
d. at night	Yes	No	a. Tuberculosis	Yes	No
e. when lying down flat	Yes	No	b. Asthma	Yes	No
2. Frequent or prolonged cough	Yes	No	c. Emphysema	Yes	No
3. Frequent colds	Yes	No	Any other Respiratory conditions:	Yes	No
4. Cough up blood	Yes	No			

HEAD, EYES, EARS, NOSE, & THROAT					
1. Unusual or severe headaches	Yes	No	4. Nose bleeds	Yes	No
2. Recent vision changes	Yes	No	5. Frequent sore throat	Yes	No
3. Head injury in the past	Yes	No			

NEUROLOGIC/PSYCHIATRIC/EMOTIONAL					
1. Mood changes	Yes	No	6. Depression	Yes	No
2. Memory loss	Yes	No	7. Seizures	Yes	No
3. Difficulty with your speech	Yes	No	8. Stroke	Yes	No
4. Nervousness	Yes	No	9. Sexual dysfunction	Yes	No
5. Anxiety	Yes	No	10. Changes in sex drive	Yes	No

GASTROINTESTINAL					
1. Jaundice	Yes	No	8. Problems with constipation	Yes	No
2. Hepatitis	Yes	No	9. Stools ever black in color	Yes	No
3. Recent nausea or vomiting	Yes	No	10. Bright red blood in stools	Yes	No
4. Recent abdominal pain	Yes	No	11. Hemorrhoids	Yes	No
5. Heartburn or Indigestion	Yes	No	12. Gallbladder disease	Yes	No
6. Stomach or duodenal ulcer	Yes	No	13. Diarrhea	Yes	No
7. Recent changes in bowels	Yes	No	14. Diverticulitis	Yes	No

ENDOCRINE					
1. Thyroid dysfunction	Yes	No	5. Hormone therapy	Yes	No
2. Diabetes	Yes	No	6. Frequent urination	Yes	No
3. Hypoglycemia	Yes	No	7. Frequent thirst	Yes	No
4. Goiter	Yes	No	8. Gout	Yes	No

URINARY					
1. Kidney infection	Yes	No	5. Blood in urine	Yes	No
2. Kidney stones	Yes	No	6. Urine color change	Yes	No
3. Incontinence	Yes	No	7. Prostate problems	Yes	No
4. Unusual pattern of urination	Yes	No	8. Decreases in kidney function	Yes	No

EXTREMITIES/ BONES/ JOINTS					
1. Excess coldness	Yes	No	7. Cramping	Yes	No
2. Deformities	Yes	No	8. Weakness	Yes	No
3. Discoloration	Yes	No	9. Stiffness	Yes	No
4. Swelling or Edema	Yes	No	10. Limitations of movement	Yes	No
5. Hair loss	Yes	No	11. Fractures	Yes	No
6. Acute or chronic pain	Yes	No	12. Back pain	Yes	No

MEDICAL CARE			
1. Regular check-ups	Yes	No	3. Males
2. Female:			a. Prostate exam
a. regular OB/GYN check-ups	Yes	No	Date: _____
b. Pap Smear	Yes	No	b. stool checked for blood
Date: _____			Date: _____
c. Mammogram	Yes	No	
Date: _____			

PERSONAL HABITS			
1. Do you smoke now?	Yes	No	4. Is your occupation sedentary?
a. What year did you start? _____			Yes
b. How many packs per day? _____			No
c. Date of last Chest X-Ray? _____			5. Do you have diet restrictions?
			Yes
			No
			If yes please describe:
2. Do you drink Alcohol?	Yes	No	6. Stress
a. How many per week? _____			Yes
b. Ever more than that previously?	Yes	No	No
3. Do you currently exercise?	Yes	No	a. Occupational
If yes please describe program:			Yes
			No
			b. Personal
			Yes
			No
			c. Recent major changes
			Yes
			No

FAMILY HISTORY		
Have any of your family members had the following? If yes, please list the relationship (mother, sister etc.)		
1. Heart Disease	Yes	No
2. Stroke	Yes	No
3. Diabetes	Yes	No
4. Hypertension	Yes	No
5. Cancer	Yes	No



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 Anton Nielsen, MD, FACC
 Stanley Duchman, MD
 John Isaac, MD, FACC
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HOSPITALIZATIONS

Please describe any hospitalizations. Please include the dates, hospital, and physician's name.

SURGERIES

Please describe any hospitalizations. Please include the dates, hospital, and physician's name.

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Year started

ALLERGIES

Please describe any allergies to MEDICINES, FOOD, or OTHER products:
