Pinehurst Medical Clinic

Patient History Form

Name : _____

Reason for Visit: _____

Your Doctors (List your doctors providing recent care *and* circle the one that referred you to us)

Doctor's Name	**Type of Doctor** *Primary Care, Urologist, etc*	**Reason for seeing this doctor**
	Primary Care Doctor	

Your Allergies Do you have allergies to drugs, food, latex, dye? ☐ YES ☐ NO

Allergy - list medication, food, latex, dye, etc.	**Reaction - rash, shortness of breath, hives, itching, etc**

Circle if you are experiencing symptoms recently or check " *No Symptoms* "

General
☐ *No Symptoms*
Decreased appetite
Fever
Recent weight loss/gain
Unusual anxiety
Depression
Panic attacks
Generally poor health overall

Eyes
☐ *No Symptoms*
Recent change in vision

Ears, Nose, and Throat
☐ *No Symptoms*
Hearing loss
Hoarseness
Nose bleeds

Respiratory
☐ *No Symptoms*
Cough
Coughing up blood
Wheezing
Snoring interfering with sleep

Cardiovascular
☐ *No Symptoms*
Chest pain, pressure or tightness
Passing out or fainting
Heart racing
Irregular heart beat
Leg pain with walking
Short of breath lying flat
Swelling of feet or ankles
Waking up short of breath

Gastrointestinal System
☐ *No Symptoms*
Bloody or black/tarry stools
Difficulty swallowing solid/liquids
Heartburn or indigestion

Hematological
☐ *No Symptoms*
Unusual bleeding or bruising
Past blood transfusion
History of blood clots

Skin
☐ *No Symptoms*
Rash
Non-healing skin ulcers

Genitourinary
☐ *No Symptoms*
Blood in urine
Pain with urination
Urination more than 2x / night
Male only:
Difficulties with erections
If yes, do you use Viagra, Cialis, or Levitra?
Female only:
Pregnant or possibly pregnant
Abnormal vaginal bleeding
Frequent urinary tract infections

Neurological
☐ *No Symptoms*
Headaches
Numbness/tingling on one side
Weakness on one side
Seizures

Endocrine
☐ *No Symptoms*
Excessive thirst
Increased urination
Use of thyroid medications

Your Past Medical History (circle all that apply below)

Cardiac Diagnostic Tests	Approximate Date(s)	Results	Normal: Yes	No
Stress test			☐	☐
Nuclear stress test			☐	☐
Cardiac Catheterization			☐	☐
Echocardiogram ('heart ultrasound')			☐	☐
Electrophysiology (EP) study			☐	☐
Cardiac CT or 'heart scan'			☐	☐
Cardiac Therapies				
Coronary angioplasty / Stent				
Coronary bypass or open heart surgery				
Ablation for heart rhythm problem				
Implantable Cardiac Defibrillator (ICD)				
Pacemaker				

Past Illnesses

Asthma
Bronchitis/Emphysema
Cancer
Diabetes
Kidney stones/kidney failure
Peptic Ulcer
Prostate
Rheumatic Fever
Seizures
Sleep Apnea
Stroke/CVA
Thyroid Disease
Other _____
_____
_____
_____

Past Cardiac Illnesses

Angina/Chest Pain
Atrial Fibrillation
Congestive heart failure (CHF)
Coronary artery disease
Heart Attack (MI)
High Blood Pressure
High Cholesterol
Irregular heartbeat (arrhythmias)
Peripheral Vascular Disease
Valve disease
Heart murmur
Other _____
_____
_____
_____
_____

Past Surgeries/Procedures

Aneurysm repair
Appendectomy
Back or neck
Breast
Carotid
Cataract
Gallbladder
Hernia
Hip or knee
Hysterectomy
Intestinal
Prostate
Tonsils/Adenoids
Other _____
_____
_____

Yes No Do you consume alcohol? Average # drinks per day _____
Yes No Do you smoke or have you smoked in the past?
Year quit (if applicable) _____
Number of years smoking?_____Average packs/day? _____
Yes No Are you on a special diet?
What type of diet? _____
Yes No Do you limit salt in your diet?

Lifestyle ☐ Single ☐ Divorced ☐ Married ☐ Widowed
Occupation _____
☐ Retired
☐ Unemployed
Yes No Do you exercise regularly?
Yes No Do you live alone?

Father ☐ Alive ☐ Deceased at age_____ ☐ Heart attack ≤ age 60? ☐ Stroke? ☐ Bypass surgery or stent? ☐ Aneurysm? ☐ Congestive heart failure?

Mother ☐ Alive ☐ Deceased at age_____ ☐Heart attack ≤ age 60? ☐Stroke? ☐ Bypass surgery or stent? ☐ Aneurysm? ☐ Congestive heart failure?

Brothers ☐ #Alive____ ☐ Deceased at age(s)_____ ☐ Heart attack ≤ age 60 ☐ Stroke ☐ Bypass surgery or stent _____ ☐ Aneurysm ☐ Congestive heart failure

Sisters ☐ #Alive____ ☐ Deceased at age (s)_____ ☐Heart attack ≤ age 60 ☐Stroke ☐ Bypass surgery or stent _____ ☐ Aneurysm ☐ Congestive heart failure

Children Any history of heart problems in your children? ☐Yes ☐No ☐ Don't have children