UNC PHYSICIANS NETWORK
UNC HEALTH CARE

# 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