Phone (573) 256-7700 * Fax (573) 256-3003

Return Visit Hospital New to Clinic

Name____**Date of Birth**__________________

ALLERGIES **Do you have ANY allergies to drugs or foods? YES or NO**

Allergy–list medication, foods, latex, etc.	Reaction–rash, shortness of breath, hives, itching, etc.

REVIEW OF SYSTEMS **Circle if you are experiencing symptoms or check "No symptoms"**

General
☐ *No symptoms*
Recent fever/chills
Recent weight loss/gain
How much?________lbs.

Integumentary (Skin)
☐ *No symptoms*
Rash (of any kind)
Changes in nails or hair
Changes in moles

Eyes
☐ *No symptoms*
Blurred vision
Double vision
Wear glasses
Glaucoma
Cataracts
Legally blind

Ears, Nose & Throat
☐ *No symptoms*
Hearing loss (hearing aid?)
Nose bleeds
Seasonal sinusitis

Psychiatric
☐ *No symptoms*
Anxiety
Stress
Depression
History of alcoholism
History of drug abuse

Respiratory
☐ *No symptoms*
Cough (dry or productive)
Coughing up blood
History of asthma, COPD or emphysema
Snoring
Short of breath at rest or exertion

Cardiovascular
☐ *No symptoms*
Chest pain, pressure, tightness or discomfort
Have you passed out?
Palpitations/irregular heart beats
Shortness of breath lying flat
Swelling of feet or ankles
History of blood clots or phlebitis

Gastrointestinal
☐ *No symptoms*
Blood in stools
Black, tarry stools
Heartburn or peptic ulcers
Acid reflux (GERD)

Musculoskeletal
☐ *No symptoms*
Muscle weakness/pain/cramps
Back pain (chronic)
Arthritis, generalized
Rheumatoid arthritis
Swelling (if so, where______________?)

Genitourinary
☐ *No symptoms*
Blood in urine
Pain with urination
History of kidney stones
Prostate problems (males only)

Neurological
☐ *No symptoms*
Headaches
Numbness/tingling on one side
Weakness on one side
Dizziness
History of TIA, stroke or seizures

Endocrine
☐ *No symptoms*
Increased fatigue
Diabetes (Do you take insulin?)
Excessive thirst
Increased urination
Hyperlipidemia
Hyperthyroidism/hypothyroidism

Hematological
☐ *No symptoms*
Bleed easily
Bruise easily
B_{12} deficiency
Bleeding disorders (anemia, etc.)
Seasonal allergies

PAST MEDICAL HISTORY

Circle past history below

Past Illnesses
Anemia
Arthritis
Asthma
Bronchitis
Cancer, if yes, what kind_______________?
Carotid artery disease
Depression
Diabetes, if yes, are you on insulin______________?
Erectile dysfunction
Gastrointestinal bleeding
Kidney stones/kidney failure/hemodialysis
Liver/gallbladder
Peptic ulcer – GERD
Prostate
Rectal bleeding
Seizures
Sleep apnea, if yes, do you wear CPAP/BIPAP?
Stroke/CVA/TIA
Thyroid disease
Other______________________________________
____
____

Infectious Diseases
Rheumatic fever
Scarlet fever
Chickenpox, measles, mumps, or rubella
Tuberculosis (TB)
Hepatitis A, B, C, D or E
HIV/AIDS
Other______________________________________
____
____

Past Cardiac Illnesses
Angina/chest pain
Atrial fibrillation (A-fib)
Congestive heart failure (CHF)
Coronary artery disease (CAD)
Heart attack (MI)
High blood pressure
High cholesterol
Irregular heartbeat (arrhythmias)
Peripheral Vascular Disease/Claudication
Pulmonary Hypertension
Endocarditis
Other____
____
____
____

Surgeries/Procedures
Appendectomy
Back
Breast
Carotid
Cataract
Gallbladder
Hernia – hiatal/inguinal
Hip
Hysterectomy
Intestinal
Knee
Amputation
Lung
Bariatric (gastric bypass, LAP-BAND)
Other____
____

Trauma History
Motor-vehicle accident
Other________________
____
____
____

Cardiac surgery/procedures (Please provide dates and location and name of doctor if available)
Cardiac catheterization______________________________
Coronary angioplasty/stent___________________________
Electrophysiology study______________________________
Pacemaker_______________________________________
Heart valve surgery__________________________________
Cardioversion_____________________________________
Coronary artery bypass______________________________
Implantable cardiac defibrillator (ICD)________________
Radiofrequency ablation______________________________

PAD Questionnaire
Does leg pain prevent you from walking normally, with family/friends, or shopping? Is it relieved with rest?____________
____
Do you ever experience coolness or pallor of feet?____

SOCIAL HISTORY & LIFESTYLE

Alcohol use

Do you consume alcohol? **YES NO**

Average number per day/week/month? Beer___________Wine_________Liquor/mixed drinks__________

Smoking/Tobacco use

Do you smoke cigarettes or use tobacco? **YES NO** Are you currently smoking? **YES NO**

Have you smoked in the past? **YES NO** How many years?______Packs per day?________

Diet

Are you on any special diet (diabetic diet, etc.)? **YES NO** If yes, what type?___________________

Do you drink caffeinated beverages? **YES NO** If yes, how many per day?____________

(coffee, tea, soda, etc.)

Exercise

Do you exercise on a regular basis? **YES NO** If so, what type of exercise?_________________

(minimum of 30 minutes per day, at least 3 times per week)

Substance abuse

Do you have any history of drug use? **YES NO**

If yes, please specify____

Lifestyle

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered

Occupation

Please list________________________________

☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

Residence

☐ Lives alone
☐ Lives with spouse/partner
☐ Lives with parents
☐ Lives with children
☐ Nursing home resident
☐ Assisted living resident

PERSONAL CARDIAC RISK FACTORS

☐ History of tobacco use
☐ Family history of heart disease *(immediate family, mother, father, brother, sister)*
☐ History of high cholesterol
☐ History of high blood pressure
☐ History of diabetes
☐ Prior history of heart disease
☐ History of obesity
☐ Sedentary/inactive lifestyle
☐ Age *(Male over age 45 – Female over age 55)*
☐ Menopausal female

FAMILY MEDICAL HISTORY

Father

- ☐ Alive
- ☐ Deceased (at what age?)____________
- Cause of death?___________________
- ______________________________
- Other______________________________
- ______________________________
- ______________________________
- ______________________________

- ☐ Heart attack (at what age_____?)
- ☐ Stroke
- ☐ Sudden cardiac death
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Congenital heart disease
- ☐ High blood pressure
- ☐ Cancer (please list what kind_______________)
- ☐ Diabetes
- ☐ Hypertension

Mother

- ☐ Alive
- ☐ Deceased (at what age?)____________
- Cause of death?___________________
- ______________________________
- Other______________________________
- ______________________________
- ______________________________
- ______________________________

- ☐ Heart attack (at what age_____?)
- ☐ Stroke
- ☐ Sudden cardiac death
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Congenital heart disease
- ☐ High blood pressure
- ☐ Cancer please list what kind_______________)
- ☐ Diabetes
- ☐ Hypertension

Sibling(s) ***Please specify brothers or sisters***

- ☐ Alive
- ☐ Deceased (at what age?)____________
- Cause of death?___________________
- ______________________________
- Other______________________________
- ______________________________
- ______________________________
- ______________________________

- ☐ Heart attack (at what age_____?)
- ☐ Stroke
- ☐ Sudden cardiac death
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Congenital heart disease
- ☐ High blood pressure
- ☐ Cancer (please list what kind_______________)
- ☐ Diabetes
- ☐ Hypertension

- ☐ Alive
- ☐ Deceased (at what age?)____________
- Cause of death?___________________
- ______________________________
- Other______________________________
- ______________________________
- ______________________________
- ______________________________

- ☐ Heart attack (at what age_____?)
- ☐ Stroke
- ☐ Sudden cardiac death
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Congenital heart disease
- ☐ High blood pressure
- ☐ Cancer (please list what kind_______________)
- ☐ Diabetes
- ☐ Hypertension

- ☐ Alive
- ☐ Deceased (at what age?)____________
- Cause of death?___________________
- ______________________________
- Other______________________________
- ______________________________
- ______________________________
- ______________________________

- ☐ Heart attack (at what age_____?)
- ☐ Stroke
- ☐ Sudden cardiac death
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Congenital heart disease
- ☐ High blood pressure
- ☐ Cancer (please list what kind_______________)
- ☐ Diabetes
- ☐ Hypertension