Missouri Heart Center
Missouri Cardiovascular Specialists

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

Please bring a copy of any recent lab work or testing.

PATIENT HISTORY FORM

Name_____**Date of Birth**_____☐**M** ☐**F**

Primary Care Physician_____ **Pharmacy**_____

Reason for Appointment_____**Height**_____

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.**

CURRENT MEDICATIONS **Please list ALL prescription medications, over-the-counter medications and vitamins!!**

Medication	**Dosage (mg, mcg, etc.)**	**How often do you take?**	**Prescribing Physician**

PERSONAL CARDIAC RISK FACTORS **Check all that apply to you**

☐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

PAST MEDICAL HISTORY **Check all that apply to you**

☐Previously healthy with no significant past history
☐Adrenal Insufficiency
☐Amyloid
☐Anemia
☐Anxiety
☐Asthma
☐Alzheimer's Disease
Arthritis: ☐Generalized
☐Gouty
☐Osteo
☐Rheumatoid
☐Bipolar Disease
☐Blind
☐BPH
☐Barrett's Esophagus
☐Bell's Palsy
☐Bronchitis-Chronic
☐Cataract
☐Cellulitis
☐Cirrhosis
☐Colitis
☐Crohn's
☐COPD
☐CVA/Stroke
☐Cancer, if yes, what kind: _____?
☐Cellulitis
☐Cirrhosis
☐Degenerative Joint Disease
☐Dementia
☐Depression
☐Diabetes:
Type: ☐ I ☐ II
☐Diabetic Neuropathy
☐Diverticulitis
☐DVT
☐Emphysema
☐Endometriosis
☐Erectile dysfunction
☐Esophagitis
☐Fibromyalgia
☐Gastric Ulcer
☐Glaucoma
☐GI Bleed
☐Gallbladder Disease
☐GERD
☐Gout
☐Hemorrhoids
☐Hernia
☐HIV
☐Hodgkin's Disease
☐Hyperlipidemia (High Cholesterol)
☐Hypertension
☐Hyperthyroid
☐Hypothyroid
☐Irritable Bowel Syndrome
☐Kidney Stone
☐Leukemia
☐Lupus
☐Lymphoma
☐Macular Degeneration
☐Migraine Headaches
☐Obesity
☐Osteoporosis
☐Pancreatitis
☐Panic Attacks
☐Parkinson's Disease
☐Peripheral Neuropathy
☐Polycystic Kidney Disease
☐Prostate
☐Pulmonary Embolus
☐Pulmonary Fibrosis
☐Renal Insufficiency
☐Renal Failure
☐Sarcoid
☐Scoliosis
☐Seizures
☐Sleep Apnea
☐Syncope (Passing Out)
☐Syncope - Near
☐TIA
☐Ulcer Disease
☐Varicose Veins
☐Vertigo
☐Other: _____

PAST CARDIAC HISTORY **Check all that apply to you**

☐No previous history of cardiac disease
☐AAA
☐ Angina (Chest Pain)
☐ASD (Atrial Septal Defect)
☐Aortic Aneurysm
Aortic Valve: ☐Stenosis
☐Regurgitation
Arrhythmia: ☐PAC's ☐PVC's
☐SVT
☐A-Fib (Atrial Fibrillation)
☐A-Flutter (Atrial Flutter)
☐Bradycardia
☐CAD (Coronary Artery Disease)
☐Cardiomyopathy
☐Carotid Artery Stenosis
☐CHF (Congestive Heart Failure)
☐Endocarditis
☐Murmur
Mitral Valve:
☐Prolapse ☐Stenosis ☐Regurgitation
☐Palpitations
☐PFO (Patent Foramen Ovale)
☐Pericarditis
☐Pulmonary Edema
☐Pulmonary Valve Stenosis
☐Pulmonary Hypertension
☐PVD (Peripheral Vascular Disease)
☐Rheumatic Heart Disease
☐Sick Sinus Syndrome
☐MI (Myocardial Infarction)
☐Myocarditis
☐S/P Cardiac Stent: _____
Tricuspid Valve: ☐Stenosis
☐Regurgitation
☐Ventricular Tachycardia
☐WPW
☐Other: _____
_____
_____
_____

INFECTIOUS HISTORY **Check all that apply to you (Please provide month/year if available)**

☐No history of infectious diseases
☐Childhood illnesses of mumps, measles and chickenpox
☐Chickenpox: _____
☐Clostridium Difficile: _____
☐COVID-19: _____
☐Diphtheria: _____
☐Gonorrhea: _____
☐Histoplasmosis: _____
☐HIV: _____
Hepatitis: : _____
☐A ☐B ☐C
☐Herpes: _____
☐Shingles: _____
☐Malaria: _____
☐Meningitis: _____
☐Measles: _____
☐Mumps: _____
☐Rheumatic Fever: _____
☐Pneumonia: _____
☐Scarlet Fever: _____
☐Syphilis: _____
☐Tuberculosis: _____
☐Typhoid Fever: _____
☐Polio: _____
☐Guillain-Barre: _____
☐Sternal Wound
☐Tick borne disease: _____

☐Vaccinations: _____
_____
_____
_____

Trauma History **Check all that apply to you (Please provide year if available)**

☐No history of trauma
☐Burns (Major) : _____
☐Skull Fracture: _____
☐Concussion: _____
☐Fracture: _____
Location: _____

☐Traumatic Amputation: _____
☐Gunshot Wound: _____
☐Stab Wound: _____
☐Wounded in the War: _____
War: _____

SURGERIES **Check all that apply to you (Please provide year if available)**

☐No prior surgical procedures
☐AAA-Repair :_____
☐AKA (Above the knee amputation) R / L: _____
☐Ankle Surgery: _____
☐AVR (Aortic Valve Replacement) :_____
☐Appendectomy:_____
☐ASD Repair:_____
☐Back Surgery:_____
☐BKA (Below the knee amputation) :_____
☐Bladder Surgery: _____
☐Breast Surgery: _____
☐CABG (Coronary Artery Bypass): _____
☐Redo-CABG: _____
☐Carotid Endarterectomy: _____
☐Cataract Extraction: _____
☐Carpal Tunnel Release: _____
☐Cesarean Section: _____
☐Colonoscopy: _____
☐Gallbladder (Cholecystectomy): _____
☐Colectomy: _____
☐D &C: _____
☐Endometrial Ablation: _____
☐Elbow Surgery: _____
☐Exploratory Lap: _____
☐Eye Surgery: _____
☐Fem-Pop Bypass: _____
☐Foot Surgery: _____
☐Gastric Surgery: _____
☐Hand Surgery: _____
☐Heart Transplant: _____
☐Hemorrhoidectomy: _____

☐Hysterectomy: _____
☐Hernia Repair: _____
☐Hip Surgery: _____
☐Knee Surgery: _____
☐Lung Surgery: _____
☐MVR (Mitral Valve Replacement): _____
☐Nasal Surgery: _____
☐Neck Surgery: _____
☐Nephrectomy: _____
☐Parathyroidectomy: _____
☐Pericardiocentesis: _____
☐PFT's (Pulmonary Function Testing): _____
☐Prostate Surgery: _____
☐Pseudo Aneurism Injection: _____
☐Shoulder Surgery: _____
☐Sleep Study: _____
☐Thyroidectomy: _____
☐Tonsillectomy: _____
☐Tonsillectomy/Adenoids: _____
☐Tubal Ligation: _____
☐TURP: _____
☐VQ Scan: _____
☐Vasectomy: _____
☐Vein Stripping: _____
☐Other: _____

_____
_____
_____
_____

CARDIAC PROCEDURES **Check all that apply to you (Please provide month /year if available)**

☐Cardiac Catheterization: _____
☐Cardioversion: _____
☐EP Study: _____
☐Internal Cardiac Defibrillator: _____
☐ICD Generator Replacement: _____
☐LVAD (Left Ventricular Assist Device): _____
☐Loop Recorder: _____
☐Ablation: _____
☐Myocardial Biopsy: _____
☐Pacemaker: _____
☐Pacemaker Generator Replacement: _____

☐PFO Closure: _____
☐PTCA (Coronary Angioplasty/Stent): _____
☐TAVR: _____
☐Mitral Clip: _____
☐Watchman: _____
☐Other:
_____
_____
_____
_____

CARDIAC TESTING **Check all that apply to you (Please provide month /year if available)**

☐ Echocardiogram: _____
☐TEE: _____
☐Treadmill Only: _____
☐ CAEP (chronotropic Assessment): _____
☐Stress Echocardiogram: _____
☐Nuclear Stress Test: _____
☐PET Scan: _____
☐MUGA Scan: _____
☐Ambulatory Blood pressure monitor: _____

☐Holter monitor: _____
☐Event monitor: _____
☐Calcium Scoring: _____
☐Other:
_____
_____
_____
_____

PERIPHERAL VASCULAR PROCEDURES/TESTING

☐AAA: _____
☐ABI: _____
☐Abdominal Aortogram: _____
☐Abdominal Angioplasty: _____
☐Arterial Doppler: _____
☐Carotid Angiogram: _____
☐Carotid Doppler: _____
☐Carotid Stent: _____
☐CTA: _____
Type: _____
☐CT: _____
Type: _____
☐Peripheral Angiogram: _____

☐Pseudoaneurysm Duplex: _____
☐Renal Doppler: _____
☐Renal Angiogram: _____
☐Renal Stent: _____
☐Venogram: _____
☐Venous Doppler: _____
☐Other:
_____
_____
_____
_____

SOCIAL HISTORY & LIFESTYLE

Alcohol use

Do you consume alcohol? ☐**YES** ☐ **NO** ☐History of Alcohol Abuse

If Yes: ☐Occasionally ☐Socially ☐Regularly ☐Heavy

☐1-2 per day ☐3-4 per day ☐More than 5 per day

☐Beer ☐Wine ☐Mixed Drinks

Smoking/Tobacco use

Do you currently smoke *cigarettes/smokeless cigarettes* or use *other tobacco* (Circle Type)? ☐**YES** ☐**NO**

Have you smoked in the past? ☐**YES** ☐**NO** How many years did you smoke _____Packs per day?_____

When did you quit? _____

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

☐No Regular Exercise ☐Some exercise ☐Exercises daily

☐Exercises on regular basis ***(30 minutes per day, at least 3 times per week)***

Type: ☐Aerobics ☐Running/Jogging ☐Walking ☐Weight Lifting

Other:_____

Substance abuse

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

If yes, please specify_____

Any IV Drug use? ☐**YES** ☐**NO**

Lifestyle

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

Occupation

Please list: _____

☐Retired ☐Unemployed ☐Student

Residence

☐Lives alone ☐Lives with others' ☐Lives in a healthcare facility

FAMILY MEDICAL HISTORY

☐Unknown ☐Adopted

Father

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

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

Mother

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

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

Sibling(s)

☐Brother ☐Sister

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

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

☐Brother ☐Sister

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

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

Children: _____

☐Alive
☐Deceased (at what age?)_____
Cause of death?_____
_____
Other_____
_____

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

REVIEW OF SYMPTOMS

General
☐No Symptoms
☐Fatigue
Unplanned recent weight ☐loss ☐gain
How Much?_____ lbs.
☐Recurrent chills and fever
☐Other:_____

Integumentary
☐No Symptoms
☐Rash ☐Hives ☐Itching
Changes in: ☐Nails ☐ Hair
☐Changes in moles ☐Hair Loss
☐Other:_____

Eyes
☐No Symptoms
☐Wears glasses/contacts
☐Decreased acuity ☐Blind
☐Blurred vision ☐Double vision (diplopia)
☐Color Blind
☐Other:_____

Ears, Nose & Throat
☐No Symptoms
Hearing loss: ☐Partial ☐Complete
☐Braces ☐Dentures
☐Hoarseness ☐Difficulty speaking
☐Nose bleeds (epistaxis)
☐Other:_____

Respiratory
☐No Symptoms
Cough: ☐Dry ☐Productive
Shortness of breath (Dyspnea):
☐At Rest ☐With Exertion
☐Daytime somnolence ☐Snoring
☐Coughing up blood (Hemoptysis)
☐Wheezing
☐Other:_____

Cardiovascular
☐No Symptoms
☐Chest pain ☐Palpitations
☐Swelling (edema):_____
Short of breath: ☐At rest ☐With exertion
☐Short of breath lying flat (orthopnea)
☐Passing out (syncope)
☐Leg fatigue/pain when walking
☐Other Cardiovascular :_____

Gastrointestinal
☐No Symptoms
☐Nausea ☐Abdominal discomfort
Blood in stool:
☐Bright ☐Dark
☐Diarrhea ☐GERD
☐Other:_____

Musculoskeletal
☐No Symptoms
☐Chronic back pain ☐Joint pain
☐Muscle weakness ☐Swelling (edema)
☐Other:_____

Neurological
☐No Symptoms
☐TIA Symptoms
☐Confusion ☐Dizziness
☐Memory deficit
☐Headaches ☐Migraines
☐Vertigo
☐Other:_____

Psychiatric
☐No Symptoms
☐Anxiety ☐Stress ☐Depression
Change in:
☐Behavior ☐Mood ☐Personality
☐Sleep disturbance
☐Other:_____

Endocrine
☐No Symptoms
☐Increased fatigue
☐Excessive thirst (polydipsia)
☐Excessive urination (polyuria)
☐Intolerance to cold
☐Other:_____

Hematological/Immunological
☐No Symptoms
☐Bleeding disorder ☐Anemia
☐Easy Bleeding ☐Easy Bruising
☐Medication Allergies ☐Seasonal Allergies
☐Swollen Lymph Nodes ☐Vitamin Deficiency
☐Other:_____