

UnityPoint Cardiology Consult

Date Completed: _____

Appointment Date: _____

Name: _____
FIRST MIDDLE INITIAL LAST

Age: _____ Birthdate: __/__/__

Referred by: _____

Family Dr.: _____

Reason for visit:

Describe briefly, include date of onset:

Doctors seen in past year:

1. _____
2. _____
3. _____

Family History:

	Age	Serious Health Problems	Age at Death if deceased	Cause
Father				
Mother				
Brother(s)				
Sisters(s)				
Children				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Social History:

Single ____ Married ____ Widowed ____ Divorced ____

Education: _____

Last grade of school completed: _____

Current/Prior Occupation: _____

Do you smoke cigarettes? ____ no ____ yes - how much _____ how long? _____

Do you chew tobacco? ____ no ____ yes - how much _____ how long? _____

Do you drink alcohol? ____ no ____ yes - how much _____ how long? _____

Do you use illegal drugs? ____ no ____ yes - how much _____ how long? _____

Do you drink caffeine? ____ no ____ yes - how much _____ how long? _____

Past Medical History: Do you have or have you been treated for:

__ Alcoholism

__ Depression

__ Kidney Disease

__ Anemia

__ Diabetes

__ Liver Disease

__ Anxiety

__ Emphysema

__ Migraine Headaches

__ Arrhythmias

__ Fainting

__ Pneumonia

__ Arthritis

__ Glaucoma

__ Polio

__ Asthma

__ Gout

__ Rheumatic Fever

__ Bleeding Disorder

__ Heart Attack

__ Scarlet Fever

__ Bronchitis

__ Heart Murmurs

__ Sleep Apnea

__ Cancer

__ Hepatitis

__ Stroke

__ Cataracts

__ Hiatal Hernia

__ Thyroid Problems

__ Congestive Heart Failure

__ High Blood Pressure

__ Tuberculosis

__ CPAP

__ High Cholesterol

__ Ulcers

__ Other (please list) _____

Past History/Major Illnesses and Date (use reverse if needed)

1. _____

2. _____

3. _____

Hospitalizations (include surgeries):

1. Where _____ When _____ How Long _____
Reason _____

2. Where _____ When _____ How Long _____
Reason _____

3. Where _____ When _____ How Long _____
Reason _____

Have you had the following tests done:

__ Chest x-ray where _____ When _____

__ EKG where _____ When _____

__ Echocardiogram where _____ When _____

__ Treadmill where _____ When _____

__ Nuclear Stress Test where _____ When _____

__ Carotid Duplex where _____ When _____

__ Other Ultrasound where _____ When _____

__ Angiogram/Stents where _____ When _____

__ CAT Scan where _____ When _____

Medications: PLEASE BRING ALL MEDICATIONS WITH YOU TO YOUR VISIT WITH THE DOCTOR

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies (Please describe any reactions to medications):

1.
2.
3.
4.

Review of Systems (check Yes if this applies to you):

Musculoskeletal	Yes	Describe
Pain or weakness:		
Upper limbs		
Lower Limbs		
Joints		
Falls		
Neurology		
Memory difficulties		
Headaches		
Numbness/tingling		
Balance difficulty		
Seizures		
Weakness		
Genitourinary		
Frequent urination		
Painful urination		
Blood in urine		
Difficulty starting urine stream		
Sexual dysfunction		

Hematologic	Yes	Describe
Easy bruising		
Fever/chills		
Sweats		
Psychiatric		
Anxiety		
Depression		
Cardiovascular		
Chest Pain: Please describe the approximate time pain began, the frequency, duration, what makes the pain start, and what makes the pain go away, in each box below.		
Sharp		
Tightness		
Heaviness		
Pressure		
At Rest		
With Exertion		
Right chest		
Left Chest		
Mid-chest		
Whole Chest		
Left/right arm pain		
Nausea		
Jaw Pain		
Shortness of Breath		
At rest		
With exercise		
Swelling of legs		
Lightheadness		
Blood clots		
Pacemaker/defibrillator		
Respiratory		
Cough		
Difficulty breathing		
Wheezing		
Night Sweats		
Gastrointestinal		
Appetite - poor/change		
Constipation		
Diarrhea		
Abdominal Pain		
Nausea/vomiting		
Bloody or black stools		
Constitutional		
Recent weight change		
Change in energy level/fatigue		
Difficulty falling asleep or staying asleep		
Recurrent fevers/sweats		

Eyes, Ears, Throat	Yes	Describe
Double vision		
Loss of vision		
Blurred vision		
Sore throat		
Difficulty swallowing		
Difficult speaking		
Hearing change		
Nosebleed		
Sinus Problem		
Bleeding of gums		
Endocrine		
Excessive thirst		
Hair loss		
Pregnancy		
Menopausal symptoms		
Abnormal menstrual cycle		
Skin		
Itching		
Skin sores		
Rashes		
Discoloration		

Signature

Date