Advanced Heart Care Group:____

Adult History Form *Name* *Date of Birth*

*Age*_____ *Referring Doctor*________________ *Family Doctor*______________________

Your answers on this form will help your health care provider better understand your medical conditions and concerns better. If you cannot remember specific details, please provide your best guess.
*****If you have completed this form in the last 30 days only complete the back of this sheet only (sections A and B.)***

PERSONAL MEDICAL HISTORY:
Please indicate whether you have any of the following medical problems:

___ Diabetes
___ High blood pressure
___ Asthma/Lung disease
___ High cholesterol
___ Enlarged Prostate
___ Gout
___ C-Spine disease
___ Anxiety
___ Glaucoma
___ Thyroid problem
___ Kidney disease
___ Depression
___ Anemia
___ Stroke
___ Cancer
___ Blood clots
___ Sleep Apnea

SURGICAL HISTORY: *Please list all prior operations or procedures (with dates):*

____

____

____

SOCIAL HISTORY:

Tobacco Use:
Cigarettes [ ] Never [ ] Quit Date ______________
[ ] Current smoker: packs/day ____ # of years ____
Other tobacco: [ ] Pipe [ ] Cigar [ ] Snuff [ ] Chew
Are you interested in quitting? [ ] no [ ] yes

Alcohol Use:
Do you drink alcohol? [ ] No [ ] Yes
#drinks/wk ______

Drug Use:
Do you ever use recreational drugs? [ ] No [ ] Yes
If yes, list: ___________________________________

Caffeine Intake:
[ ] No [ ] Coffee/Tea/Soda ___ cups/day

Diet:
[ ] Regular [ ] Diabetic [ ] Low Salt
[ ] Low fat [ ] Weight loss

Exercise:
Do you exercise regularly? [ ] No [ ] Yes

Occupation: ______________________________

Employer: ________________________________

Marital Status: Single Married Divorced Widow

# of Children: ____________________________

FAMILY HISTORY: *Please indicate family members (parent and/or sibling,) with any of the following conditions: If none, please indicate none.*

Heart Disease ______________________________

Heart Attack _______________________________

Diabetes __________________________________

High Blood pressure _________________________

Weak Heart Muscle __________________________

High cholesterol ____________________________

Irregular Heart Rate _________________________

Stroke ____________________________________

A. REVIEW OF SYSTEMS:

Please check any symptoms that you have:

____ Cough
____ Shortness of breath
____ Shortness of breath with exercise
____ Snoring
____Frequent upper respiratory infections/symptoms
____ Productive cough
____ Blood in sputum
____ Shortness of breath relieved with standing
____ Shortness of breath when lying down
____ Snoring
____ Wheezing
____ Sneezing
____Nasal congestion
____ Hoarseness
____ Difficulty swallowing
____ TB exposure
____ Chills
____ Fatigue
____ Fever
____ Insomnia
____ Night sweats
____ Weakness
____ Weight gain
____ Weight loss
____ Sensitivity of light
____ Vision changes
____ Glaucoma
____ Hearing loss
____ Ringing in ears
____ Nasal Drainage
____ Nosebleeds
____ Sinus infection
____ Palpitations
____ Fluttering in chest
____ Fainting
____ Near fainting
____ Cramps in legs
____ Cramps in legs with activity that is relieved with rest
____ Swelling of legs/ankles
____ Pain in legs
____ Sores on lower legs
____ Chest pain
____ Chest heaviness
____ Chest pressure
____ Chest pain with activity
____ Abdominal pain
____ Abdominal swelling/bloated
____ Loss of appetite
____ Constipation
____ Diarrhea
____ Nausea
____Vomiting
____ Gas
____ Blood in vomit
____ Indigestion/heartburn
____ Blood in stools
____ Hemorrhoids
____ Acid Reflux
____ Burning with urination
____ Discolored or cloudy urine
____ Frequent urination
____ Groin mass
____ Blood in urine
____ Frequent urination at night
____ Testicular pain or swelling
____ Erectile dysfunction
____ Cold intolerance
____ Heat intolerance
____ Difficulty with speech
____ Dizziness
____ Unsteady gait
____ Headaches
____ Problems with coordination
____ Memory loss
____ Numbness in extremities
____ Seizures
____ Tremors
____ Vertigo
____ Anxiety
____ Depression
____ Irritability
____ Increased stress
____ Nervousness
____ Sleep disturbances
____ Rash
____ Skin sores
____ Back pain
____ Bone pain
____ Joint pain
____ Joint stiffness
____ Muscle cramps or spasms
____ Easy bruising
____ Easy bleeding
____ Anemia
____ Low platelet count

B. Main reason for today's visit:

____

C. Please indicate below if you have had any recent hospitalizations, recent illness or surgery. Please indicate where, when and what:

____

____

Please indicate below who you would like us to contact in the case of an emergency:

______________________________ Name
______________________________ Phone Number (s)

Please indicate below the name and fax number of your preferred pharmacy. If you do not have the fax number please indicate the name of the pharmacy and the street it is located on:

______________________________ Name of pharmacy
______________________________ Number or street address

MEDICATIONS

Name	Dosage (mgs)	Frequency Taken (i.e. once a day)	Date last taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Advanced Heart Care group physicians encourage you to see all the physicians in the practice. This allows the physicians to meet you and know your history in emergency situations. However, if you prefer to see the same physician for all appointments, please let us know. We will do our best to accommodate you.