The Heart & Lung INSTITUTE OF UTAH

CARDIOLOGY PATIENT HEALTH HISTORY QUESTIONNAIRE (Please complete both pages)

Patient Name:	Age:	Height:	Weight:
Primary Care Physician:			

Briefly describe reason for today's visit:

Medical Problems / Hospitalizations / Surgeries

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Other Medical History: (check box)

- ❑ Elevated Cholesterol
- ❑ Diabetes
- ❑ High Blood Pressure

Medication Allergies / Reactions:

Your Social History:

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Children: ❑ Yes ❑ No Number:_____

Tobacco: ❑ Cigarettes ❑ Cigars ❑ Pipe

_____Packs / day

Age started smoking? _____

Age when quit? _____

Still smoking? ❑ Yes ❑ No

Substance Use:

- ❑ Caffeine
- ❑ Alcohol drinks/ week:_____
- ❑ Drugs:_____

Your Family History:

Please check illnesses that have occurred in your blood relatives? (check box, describe and indicate relatives).

❑ Cholesterol	Relative(s)	❑ Tuberculosis	Relative(s)
❑ Strokes		❑ Cancer (Type) _____	
❑ Coronary Artery Disease		❑ Heart Disease	
❑ Diabetes		❑ Heart Attacks	
❑ Hypertension		❑ Heart Rhythm Problems	

Employment History:

Are you working now? ❑ Yes ❑ No

What is (or was) your occupation?

Reviewing Physician Signature _____ Date _____

-BELOW-

Patient Name:

Have you ever had: (check)

General
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Fatigue/ Weakness
- ❑ Fever
- ❑ Excessive Sleepiness
- ❑ Heavy Snoring
- ❑ Rash

Head
- ❑ Headache
- ❑ Head Injury

Eyes
- ❑ Vision Changes
- ❑ Last Eye Exam ___/___/___

Hearing
- ❑ Hearing Loss
- ❑ Ringing
- ❑ Dizziness
- ❑ Earaches
- ❑ Infection

Nose / Sinuses
- ❑ Frequent Colds
- ❑ Nasal Stuffiness
- ❑ Discharge
- ❑ Hayfever
- ❑ Nosebleeds
- ❑ Sinus Trouble

Neck
- ❑ Lumps

Mouth
- ❑ Sore Throat
- ❑ Bleeding Gums
- ❑ Hoarseness

Breasts
- ❑ Lumps or Nipple Discharge

Lung Problems
- ❑ Cough
- ❑ Sputum
- ❑ Bloody Sputum
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Short of Breath
- ❑ Last Chest X-ray ___/___/___ (date)

Sleep
- ❑ Weight gain
- ❑ Daytime Sleepiness / fatigue
- ❑ Snoring
- ❑ Necksize _____inches
- ❑ Morning Headache
- ❑ Gasping or Choking During Sleep
- ❑ Restless Sleep
- ❑ Heartburn During Sleep
- ❑ Memory Loss / Irritability

Heart Problems
- ❑ High Blood Pressure
- ❑ Chest Pain or Discomfort
- ❑ Breathlessness with Exertion
- ❑ Breathlessness while Lying Flat
- ❑ Swelling of Lower Extremities
- ❑ Heart Attack ___/___/___ (date)
- ❑ Heart Surgery ___/___/___ (date)

Vascular
- ❑ Pain in calf, thigh, buttocks while walking
- ❑ Cold feet
- ❑ Blue or pale toes
- ❑ Non-healing ulcers on legs

Have you ever had: (check)

Cancer Type _____ When_____

Endocrine
- ❑ Thyroid Trouble
- ❑ Diabetes
- ❑ Excessive Thirst or Hunger

Stomach / Intestinal
- ❑ Difficulty Swallowing
- ❑ Painful Swallowing
- ❑ Heartburn
- ❑ Decreased Appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bleeding from the Rectum
- ❑ Hemorrhoids
- ❑ Tarry Black Stools
- ❑ Abdominal Pain
- ❑ Liver or Gallbladder Trouble
- ❑ Hepatitis

Kidneys / Bladder
- ❑ Increased Urine Frequency
- ❑ Increased Urination at Night (___times / night)
- ❑ Burning or Pain with Urination
- ❑ Bloody Urine
- ❑ Difficulty in Starting Urine Stream
- ❑ Urinary Tract Infections
- ❑ Kidney Stones
- ❑ Poor kidney function (elevated creatinine)

Male
- ❑ Hernia
- ❑ Testicular Pain
- ❑ Venereal (Sexually Transmitted) Disease
- ❑ Impotence
- ❑ Last rectal / prostate exam by Dr. _____

Female
- ❑ Abnormal Vaginal Bleeding
- ❑ Venereal (Sexually Transmitted) Disease
- ❑ Last Pelvic Exam / Pap Smear _____
- ❑ Last Breast Exam _____
- ❑ Last Mammogram _____

Muscle / Skeletal
- ❑ Muscle or Joint Pains
- ❑ Arthritis
- ❑ Gout
- ❑ Joint Swelling

Skin
- ❑ Rash, Dryness, Itching

Psychiatric
- ❑ History of Psychiatric Hospitalization
- ❑ Depression
- ❑ Anxiety

Blood / Lymph System
- ❑ Anemia
- ❑ Easy Bruising or Bleeding
- ❑ Blood Clots in the Legs or Lungs
- ❑ Transfusions or Transfusion Reactions
- ❑ Swollen Lymph Nodes
- ❑ Lymphoma
- ❑ Leukemia

Neurologic
- ❑ Fainting
- ❑ Seizure
- ❑ Paralysis
- ❑ Stroke
- ❑ Numbness
- ❑ Tingling
- ❑ Brain Tumor

Immunologic
- ❑ Other Allergies _____
- ❑ Lupus
- ❑ Vasculitis

Patient Signature: Date: Reviewing MD: Date: