

JACKSON HEART CLINIC, P.A.
Medical History Questionnaire

1) **Today's Date**

Month Day Year

Please Print

First

Middle

Last

2) Name: _____ Age: _____ Sex: _____

3) Referring Doctor: _____

Please answer all questions in all sections that apply to you. Your answers are confidential and will be reviewed in private by the doctor.

4) Briefly state what particular problem or symptoms brings you to us: _____

5) Have you ever been told that you had: (If yes, give dates.)

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart failure (fluid on the lungs) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic heart disease, Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart defect from birth |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac catheterization (heart cath) |
| <input type="checkbox"/> | <input type="checkbox"/> | Treadmill exercise test |

6) **Cardiac Risk Factors**

Diabetes (on meds or insulin) ___ Yes ___ No Age of onset _____

High blood pressure ___ Yes ___ No

 On medicine ___ Yes ___ No

Abnormal cholesterol ___ Yes ___ No

 Last cholesterol _____ Triglyceride _____ HDL _____ LDL _____

Smoking - 1) Cigarettes _____ Never _____ Current _____ Former When stopped _____

 If current, cigarettes per day _____ Total pack years _____

 2) Pipe/cigar _____ Never _____ Current _____ Former When stopped _____

 3) Smokeless tobacco _____ Yes _____ No

Family History of heart attack/or heart surgery ___ Yes ___ No

7) Do you currently experience episodes of chest pain ___ Yes ___ No

 If NO skip to #8 (page 3)

What types of chest pains do you have?

- Sharp
- Stabbing
- Pressing
- Aching
- Tightness
- Squeezing
- Fullness
- Tingling
- Burning
- Other

Does the pain come on suddenly? Yes No

Does the pain come on gradually? Yes No

How long does the pain last?

- Few seconds
- More than 10 minutes
- Days
- Less than 10 minutes
- Hours

Is the pain or discomfort associated with:

- Nausea
- Weakness
- Gas or Belching
- Shortness of breath
- Sweating
- Fast heart beat
- Light-headedness
- None of the above

Make a check by all activities that cause pain.

- Walking If so, how far? _____
- Climbing stairs How many? _____
- Carrying objects How far? _____
- After meals
- Sexual intercourse
- Walking up hills
- Doing your daily work
- Pain that occurs at rest without activity
- Pain that awakens you from sleep
- Pain that occurs with emotional stress
- None of the above

Is the pain made worse by:

- Taking a deep breath
- Swallowing
- None of the above
- Coughing
- Eating

Does the pain move:

- To the neck
- To the back
- To the chest from the arm or neck
- None of the above
- To the shoulder
- To the elbow or arm
- To the jaw

Lately, has the pain become more severe or become more frequent? Yes No

Since when? _____

What have you found to relieve the pain?

- Stopping activity and resting
- Aspirin or other pain pills
- Nitroglycerin (under the tongue)
- Antacids (Maalox, Gelusil, etc.)
- Other: _____
- Nothing

How frequently does the pain occur?

- Several times a day
- Once a day
- Once a week
- Every few months
- Constantly
- Depends upon your activity

8) Cardiac systems review

Have you had difficulty with shortness of breath
When?

- sitting still
- walking on level ground
- climbing stairs or walking up hills
- only with unusually heavy exertion
- that awakens you from sleep

- Do you have swelling in your feet Yes No
- Do you awaken at night to urinate Yes No
- Have you ever fainted or nearly fainted Yes No
- Do you have irregular, slow, fast or skipping heart beats Yes No
- Do you have pain in the legs or hips when walking Yes No

9) Past Medical History

Do you have any known medical problems which are currently under treatment, medications or diet alone? _____

10) Past surgical experience

Please list any previous surgical procedures including those during your childhood and minor surgical procedures such as removal of skin lesions or eye surgery.

- 1. _____ 4. _____ 7. _____
- 2. _____ 5. _____ 8. _____
- 3. _____ 6. _____ 9. _____

11) Medications

Please list below all medications you are currently taking, including any non-prescriptions drugs which you frequently use.

- 1. _____ 5. _____ 9. _____
- 2. _____ 6. _____ 10. _____
- 3. _____ 7. _____ 11. _____
- 4. _____ 8. _____ 12. _____

12) Allergies

A. Do you have any known drug or dye allergies Yes No

If yes, please describe the symptom associated with the allergic reaction and list drug involved.

13) Family History

Is there a family history of:

- high blood pressure cancer sudden death
- stroke diabetes bleeding tendency

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR FINDINGS:

General

- Skin rash
- Lethargy/weakness
- Loss of interest in eating
- Always hungry
- Tend to be hot or cold
- Chills/night sweats
- Sleeping difficulties
- Unusual hair loss
- Weight change

Head

- Frequent or severe headaches
- Dizzy spells
- Fainting spells/unconsciousness

Eyes

- Wear Glasses
- Eyesight worsening
- See double
- Eye pains or itching

Ears

- Deafness
- Earaches or drainage
- Noise in ears
- Decreased hearing

Nose

- Congestion/sneezing
- Sinus trouble/hay fever
- Nose bleeds

Throat

- Sore throat or tongue
- Hoarse voice
- Dental problems
- Goiter/thyroid problems
- Neck pains or lumps

Lungs

- Wheezing/coughing spells
- Cough up phlegm
- Shortness of breath
- Emphysema
- Cough up blood
- Exposed to TB
- Lung clot
- Pleurisy
- Swollen feet or ankles
- Asthma
- Pneumonia
- Tuberculosis

GI

- Heartburn or indigestion
- Belching or nausea
- Jaundice
- Difficulty swallowing
- Stomach pains
- Vomiting blood
- Constipation
- Recent change in bowel habits
- Loose stools/diarrhea

GU

- Frequent night or day voiding
- Burning on urination
- Pus or blood in urine
- Difficulty starting urine
- Dribbling with coughing/sneezing

NM

- Convulsions/seizures
- Stroke/paralysis
- Memory problems
- Cry often/depressed/feel sad
- Considered suicide
- Polio or meningitis

Heme-Endo

- Bleed/bruise easily
- Anemia/low blood
- Blood disease
- Enlarged glands/nodes
- Known thyroid disease

MEN ONLY

- Weak urine stream
- Prostate trouble
- Lump on testicles
- Impotence
- Change in sex desire
- Burning or discharge

WOMEN ONLY

Check if you have had or complete as requested the items indicated below:

- Cesarean section
- Hysterectomy
- Toxemia
- Lumps in breast

Date of last Pap Smear: _____

Number of pregnancies: _____

Number of miscarriages: _____

Any menstrual problems? _____

Date last menstruated: _____

- Black or bloody stools
- Pain in rectum
- Hemorrhoids
- Amoeba/parasites
- Cirrhosis
- Hepatitis
- Ulcers
- Pancreatitis
- Gallbladder problems

- Kidney stone
- Sex difficulties
- Other kidney disease
- Venereal disease

- Gout
- Phlebitis
- Varicose veins
- Aching muscles/joints
- Leg Cramps/pains
- Pain in hands or feet after cold exposure

- Spells of sweating or trembling
- Cancer
- Prolonged fever