



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Page 2

Pharmacy name and phone number: \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

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If you have ever had any of the problems listed below, please explain.

<b>Problem</b>	<b>Explanation</b>
<b>GENERAL</b> (Fatigue, changes in weight)	
<b>INTEGUMENT</b> (Skin)	
<b>EYES</b> (Eyes including glaucoma)	
<b>HEENT</b> (Ears, nose, mouth, throat)	
<b>RESPIRATORY</b> (Lungs or breathing)	
<b>GASTROINTESTINAL</b> (Stomach or intestines)	
<b>GENITOURINARY MALE</b> (Prostate, kidney, bladder)	
<b>GENITOURINARY FEMALE</b> (Kidney, bladder, uterus, ovaries)	
<b>MUSCULOSKELETAL</b> (Bones, joints, muscles)	
<b>NEUROLOGICAL</b> (Strokes, seizures, Alzheimer's, dementia, nerve damage)	
<b>PSYCHIATRIC</b> (Emotional, drugs, alcohol)	
<b>ENDOCRINE</b> (Thyroid, adrenals, diabetes)	
<b>HEMATOLOGICAL/IMMUNOLOGICAL</b> (Blood, bruising, immune system)	

**Heart and Blood Vessel History (Cardiac Timeline)**

List all of your heart and blood vessel (vascular) procedures and major problems. These include heart attacks, strokes, catheterizations, angioplasty/balloon procedures, stents and heart and blood vessel operations.

Problem/Procedure	Date

**Past Surgical History**

**Have you ever had any of the following surgeries?:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> No Prior Surgeries                              | <input type="checkbox"/> Cataract (right/left/both)            | <input type="checkbox"/> Melanoma                         |
| <input type="checkbox"/> Abdominal Aneurysm Surgery                      | <input type="checkbox"/> Cesarean Section                      | <input type="checkbox"/> Prostate                         |
| <input type="checkbox"/> Appendix  | <input type="checkbox"/> Cholecystectomy (Gallbladder)         | <input type="checkbox"/> Splenectomy (Spleen Removal)     |
| <input type="checkbox"/> Arthroscopic Knee Surgery (right/left/both)     | <input type="checkbox"/> Gastric Stapling                      | <input type="checkbox"/> Shoulder (right/left/both)       |
| <input type="checkbox"/> Back  | <input type="checkbox"/> Hemorrhoid Repair                     | <input type="checkbox"/> Thyroid                          |
| <input type="checkbox"/> Bladder   | <input type="checkbox"/> Hysterectomy                          | <input type="checkbox"/> Tonsil/Adenoids                  |
| <input type="checkbox"/> Breast Surgery - cosmetic (right/left/both)     | <input type="checkbox"/> Hernia Repair (right/left/both)       | <input type="checkbox"/> Tubal Ligation                   |
| <input type="checkbox"/> Breast Biopsy                                   | <input type="checkbox"/> Hip Replacement (right/left/both)     | <input type="checkbox"/> TURP (Prostate Procedure)        |
| <input type="checkbox"/> Breast Surgery - lumpectomy (right/left/both)   | <input type="checkbox"/> Knee Replacement (right/left/both)    | <input type="checkbox"/> Ulcer Surgery                    |
| <input type="checkbox"/> Breast Surgery - mastectomy (right/left/both)   | <input type="checkbox"/> Laminectomy (Back Surgery)            | <input type="checkbox"/> Vasectomy                        |
| <input type="checkbox"/> Carotid (Neck Artery) Surgery (right/left/both) | <input type="checkbox"/> Lobectomy (Lung Surgery) (right/left) | <input type="checkbox"/> Vein Stripping (right/left/both) |
| Other Operations _____   | Other Operations _____   |   |
| Other Operations _____   | Other Operations _____   |   |
| Other Operations _____   | Other Operations _____   |   |

**Social History (Check all that apply to you.)**

I am  single/never married  separated  divorced  widowed  married since \_\_\_\_\_ (year)

I live with  my spouse  my child/children  alone  other \_\_\_\_\_

I work  I am retired. My job is/was \_\_\_\_\_

I do not drink alcohol  I have (number) \_\_\_\_\_ drinks of  beer  wine  mixed drinks  
 every  day  week  month

I have (number) \_\_\_\_\_ drinks of  coffee  tea  cola each day

**Family History**

I have \_\_\_\_\_ (number) sisters, \_\_\_\_\_ (number) brothers, and \_\_\_\_\_ (number) children.

Family Member	Alive or Deceased	Age or Age at Death	Medical Problems or Cause of Death	Coronary Artery Disease (Yes/No) If yes, age first noted
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Brother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Brother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Children	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Grandparents	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Other	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____
Other	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age: _____

**Cardiac Risk Factors (Check all that apply to you.)**

Have you ever smoked cigarettes, cigars or a pipe?  Yes  No

If yes, how many years did you smoke? \_\_\_\_\_ Number of packs per day \_\_\_\_\_

- I quit smoking (*date stopped smoking:* \_\_\_\_\_)
- I still smoke  cigarettes  pipe  cigars

Have you ever been told you had high cholesterol or high triglycerides?  Yes  No

If yes, what year were you first told that you had this problem? \_\_\_\_\_ Date of last cholesterol test \_\_\_\_\_

Results if known: total cholesterol \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ triglycerides \_\_\_\_\_

Have you ever been told you had high blood pressure?  Yes  No

If yes, what year were you first told that you had high blood pressure? \_\_\_\_\_

Have you ever been told you had diabetes or high blood sugar?  Yes  No

If yes, what year were you first told that you had diabetes or high blood sugar? \_\_\_\_\_

- Treated with diet only  Treated with pills  Treated with insulin  Treated with insulin and pills

**Additional Information**

Please write below any other information not covered in the questionnaire that you think is important to your cardiac care or that you would like to discuss with your doctor or bring to your doctor's attention.

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I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

Please fill out this questionnaire and either fax to (407) 650-1307 or deliver to Orlando Heart Center on your next appointment. A triage nurse will be contacting you approximately 2 days prior to your appointment to review this questionnaire with you.