Valley Heart Associates
KLEE & STEVENSON

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PATIENT MEDICAL HISTORY

Welcome to Valley Heart Associates!

Please complete the following questionnaire so that our physicians may best assess your needs.

Name:	Date:
Referring Physician:	Preferred Hospital:
Preferred Pharmacy & Address: **Phone:**	
Reason for today's visit (symptoms):	

1. Have you had CHEST DISCOMFORT?	YES NO	If yes, please answer 1a-i

a. Describe the discomfort. (sharp, dull, etc.):

b. How often does it occur (daily weekly, monthly)?

c. What precipitates or aggravates the discomfort?

d. Does it radiate to your ARM BACK or NECK? (if yes, circle which one)

e. Do you ever sweat during this discomfort? YES NO

f. Do you ever become nauseated? YES NO

g. Does it happen when you exert yourself? YES NO

h. Does it happen when you are under stress? YES NO

i. Does nitroglycerin help to ease the discomfort? YES NO DON'T KNOW

If YES, how long (minutes) is it before the medication eases the discomfort? _____ MINUTES

2. Have you ever had a heart attack?	YES NO	If yes, please answer 2a-c

a. Date:

b. Name of Physician:

c. Name of Hospital:

3. Have you ever had coronary bypass surgery or any other type of heart surgery?	YES NO	If yes, please answer 3a-c

a. Date of surgery:

b. Name of Surgeon:

c. Name of Hospital:

4. Please list the most vigorous activity that you perform (i.e., walking, housework, running, etc.) and what, if anything, limits that activity (chest pain, shortness of breath, leg pain, fatigue, etc.):

5. If you have had one of the following procedures, please list the date, place and physician involved:

Procedure	Date	Place	Physician
CARDIAC CATHETERIZATION (a dye study of the arteries of the heart sometimes referred to as an ANGIOGRAM)			
ANGIOPLASTY (balloon)			
ECHOCARDIOGRAM (ultrasound of the heart)			
STRESS TEST (treadmill)			
Chest x-ray			
EKG			

6. Please list any chronic medical problems (diabetes, high blood pressure, etc)

7. Please list your past surgeries, including date, hospital and name of surgeon. If you don't recall the exact date, please provide the year.

Surgery	Date	Place	Surgeon

8. Please list all current medications you are taking, including dosage and frequency.

Medication Name	Dosage	Frequency

9. Are you allergic to any medications or foods? YES NO

If YES, please list and state what type of reaction you had:

10. Have you ever had a reaction to INTRAVENOUS DYE SHELLFISH or IODINE (please circle).

If YES, please describe the reaction:

11. Does anyone in your family have a cardiac problem? YES NO

If YES, please list their relationship to you, age of onset and their current health:

RELATIONSHIP	AGE OF ONSET	CURRENT HEALTH

PERSONAL INFORMATION

Birthplace:	Employment:
Marital Status:	Number of children:
Do you smoke: YES NO If previously, how long ago did you quit?	Do you drink alcohol? YES NO If YES, how often?

Please list your hobbies:

DO YOU HAVE OR HAVE YOU EVER HAD (please circle YES or NO):		
High Blood Pressure?	YES	NO
Heart failure or heart enlargement?	YES	NO
Irregular heartbeat or palpitations?	YES	NO
Shortness of breath?	YES	NO
Shortness of breath with exertion?	YES	NO
Trouble breathing when you lie down flat? If YES, how may pillows do you use to sleep? _____	YES	NO
Wake in the middle of the night with shortness of breath?	YES	NO
Swelling of the feet or ankles?	YES	NO
Recent weight gain from fluid retention?	YES	NO
Fainting spells?	YES	NO
Stroke or near stroke?	YES	NO
Pain in your legs when you walk from narrowing of the arteries?	YES	NO
Rheumatic fever as a child?	YES	NO
Valvular disease or heart murmur?	YES	NO
Inflammation of the muscle sack around the heart?	YES	NO
Peptic ulcer disease?	YES	NO
Have you ever vomited blood?	YES	NO
Hiatel hernia?	YES	NO
Blood in your stool?	YES	NO
Tendency to bleed easily?	YES	NO
Hepatitis?	YES	NO
Any type of IV drug use?	YES	NO
Blood clots in legs or lungs?	YES	NO
Any kind of cancer?	YES	NO
Diabetes?	YES	NO
Asthma or Emphysema?	YES	NO
Kidney Failure?	YES	NO
High Cholesterol?	YES	NO
Please list any other symptoms that you feel apply, but are not listed above:		