UNIVERSITY CARDIOLOGY

UT Medical Center
Heart Lung Vascular Institute
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HISTORY AND PHYSICAL

Name____ Date____________________
Last First M i d d l e

Birthdate____ Age____________________

Were you referred to us?______________ If yes, by whom______________________________________

History of Present Illness

Briefly describe your reason(s) for this visit (Chief Complaint)______________________________________

Have you been to the emergency room recently? If yes, please explain.___________________________

Medication

List current medications you are taking routinely or when needed (include prescription & non-prescription drugs). Use back if needed.

DRUG	DOSE	FREQUENCY	REASON

Allergies: Please describe reaction

PLEASE COMPLETE ALL FOUR PAGES OF THIS FORM

Social History

Present occupation________________________________ List any previous occupations______________________________

____

Marital Status (circle) Married Divorced Widowed Separated Single

Spouse's Name____

Religious Preference, if any____

Have you ever smoked?__________ If yes, how many years___________ When did you quit?_________________

If still smoking, how many packs per day?______________ What age did you start smoking?____________________

Highest level of education. _____Grade School _____High School _____College _____Post Graduate

Do you drink alcohol?_________________ How many drinks daily/weekly?_____________________________________

Do you currently use drugs (e.g. cocaine, marijuana, heroin, etc.)? If yes, please explain:____________________________

____

What was your most recent cholesterol level?____

Family History (include diabetes, heart disease, stroke, cancer, lung disease, kidney disease, high blood pressure, etc.)

Father: Alive______ Current Age________ Deceased______ Age________ Cause______________________
Illnesses____

Mother: Alive______ Current Age________ Deceased______ Age________ Cause______________________
Illnesses____

Siblings: Number of brothers_________ Illnesses____

Number of sisters____________ Illnesses____

Do you have children?__________ How many?__________ Ages____
Illnesses____

Past Medical History

Do you have or have you ever had ?

_____ High Blood Pressure
_____ Heart Attack
_____ Heart Disease
_____ Cancer
_____ Breast Masses
_____ Thyroid Disease
_____ Bleeding Problems
_____ Stomach Disease
_____ Nervous Problems
_____ Glaucoma

_____ Diabetes (Sugar)
_____ Stroke
_____ Rheumatic Fever
_____ Emphysema
_____ Sexually Transmitted Disease
_____ Blood Clots
_____ Blood Transfusions
_____ Colon Disease
_____ Arthritis
_____ Scarlet Fever

_____ High Cholesterol
_____ Seizures
_____ HIV Testing
_____ Pneumonia or TB
_____ AIDS
_____ Anemia (Low Blood)
_____ Liver Disease/Hepatitis
_____ Prostate Disease
_____ Gout
_____ Kidney Disease

Have you gone through menopause? (women only)_______________

If yes, are you currently taking hormones?_____________ If yes, please list on medication chart from page one.

Surgeries

List any surgeries you have had (include date)____

____

____

Other

Please list any other illnesses, diseases or hospitalizations not mentioned (include childbirth)_____________

____

____

Immunizations

_____ Pneumonia _____ Shingles _____ Hep B _____ Tetanus _____ TB Skin Test __________ Result

System Review (mark any of the following symptoms you have problems with)

Musculoskeletal	**Hematologic / Lymphatic**	**Allergic / Immunologic**	**Integumentary**	**Psychiatric**
_____ Back pain	_____ Swollen glands	_____ Frequent colds or flu	_____ Rash	_____ Anxiety
_____ Arthritis	_____ Excessive bruising	_____ Allergies	_____ Skin problems	_____ Depression
_____ Muscle	_____ Abnormal bleeding	_____ Frequent sinus infections	_____ Abnormal lumps or growths	

General	**Eyes and Ears**	**Nose, Mouth and Throat**	**Cardiovascular**	**Respiratory**
_____ Fever	_____ Vision changes	_____ Voice changes	_____ Chest pain	_____ Shortness of breath
_____ Weight loss	_____ Hearing loss	_____ Hoarseness	_____ Heart racing	_____ Abnormal cough
_____ Weight gain	_____ Ear pain	_____ Frequent sore throats	_____ Swelling of ankles/legs	_____ Wheezing
_____ Poor appetite	_____ Eye pain	_____ Dental problems		_____ Coughing up sputum/blood

Gastrointestinal	**Neurological**	**Genitourinary**	**Endocrine**
_____ Nausea / Vomiting	_____ Dizziness	_____ Blood in urine	_____ Frequent thirst
_____ Bloody or black stools	_____ Numbness or tingling	_____ Cloudy urine	_____ Increased appetite
_____ Difficulty swallowing	_____ Blackouts	_____ Pain with urination	_____ Weakness
_____ Frequent heartburn	_____ Tiredness	_____ Frequent urination	_____ Increased sweating
_____ Diarrhea	_____ Sleep problems		
_____ Constipation	_____ Headaches		

1. Do you get pain or discomfort in your leg(s) when you walk?

Yes ____ No _____

2. Does this pain ever begin when you are standing still or sitting?

Yes ____ No _____

3. Do you get pain if you walk uphill or hurry?

Yes ____ No _____

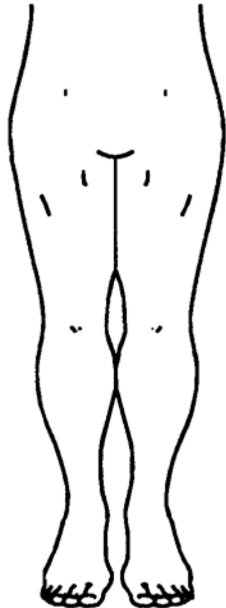
4. Do you get pain if you walk at an ordinary pace on level ground?

Yes ____ No _____

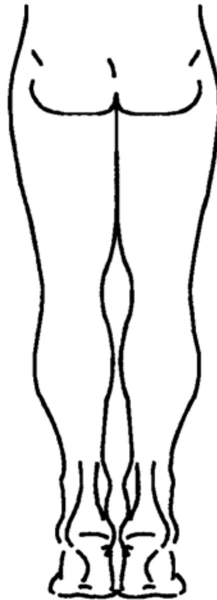
5. If you stand still is the pain gone in ten minutes or less?

Yes ____ No _____

6. Where do you get this pain? Mark below



Front
Right Left



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