Cardiovascular Surgeons, P.A.

EVALUATION AND MANAGEMENT HISTORY INFORMATION FORM

Date ______________ Patient Name ______________________________________

Date of Birth ____________________ Age __________ Sex ☐ Male ☐ Female

____ ____

General Practitioner/Primary Doctor Refering Physician/Specialist

REVIEW OF SYSTEMS - PLEASE CHECK EACH ITEM "YES" OR "NO"
AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL	Yes	No
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Change in Appetite	☐	☐

EYES	Yes	No
Glasses / Contacts	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

EAR, NOSE, THROAT	Yes	No
Ringing in ears	☐	☐
Vertigo	☐	☐
Frequent Sore Throat	☐	☐
Hoarseness	☐	☐
Frequent Nosebleeds	☐	☐

GENITOURINARY	Yes	No
Pain Urinating	☐	☐
Burning	☐	☐
Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
History of Sexually Transmitted Disease	☐	☐

RESPIRATORY	Yes	No
Shortness of Breath	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Persistent Cough	☐	☐
Frequent Infections	☐	☐

GASTROINTESTINAL	Yes	No
Abdominal Pain	☐	☐
Nausea / Vomiting	☐	☐
Heartburn	☐	☐
Rectal Bleeding	☐	☐
Blood / Black Stools	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

CARDIOVASCULAR	Yes	No
Chest Pain	☐	☐
Jaw Pain	☐	☐
Arm Pain	☐	☐
Calf Pain	☐	☐
Palpitations	☐	☐
Swelling of Extremities	☐	☐

HEMATOLOGIC	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
Prolonged Bleeding	☐	☐

MUSCOLOSKELETAL	Yes	No
Joint Pain / Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐

NEUROLOGICAL	Yes	No
Seizures	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Memory Loss	☐	☐
Loss of Consciousness	☐	☐

SKIN	Yes	No
Rash / Sores	☐	☐
Lesions	☐	☐
Itching	☐	☐
Burning	☐	☐

	Yes	No	(If "yes," please list details):
1. Have you ever had a vein stripping?	☐	☐	____________________
2. Have you ever had chest trauma?	☐	☐	____________________
3. Have you ever had a problem with anesthesia?	☐	☐	____________________
4. Have you ever had a blood transfusion?	☐	☐	____________________
5. Do you object to receiving blood products?	☐	☐	____________________

PAST PATIENT HISTORY - Please list below ALL Your Past Operations, Hospitalizations, Illnesses/Injuries PLEASE BE SPECIFIC AS TO REASON AND DATES	
Please list all past operations/hospitalizations with reason & date	Please list all personal illnessess/injuries and dates

PAST PATIENT HISTORY - PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR PAST PERSONAL HISTORY					
CONDITION	Yes	No	CONDITION	Yes	No
INFECTIOUS DISEASES			**ENDOCRINE**		
Hepatitis	☐	☐	Diabetes	☐	☐
HIV/AIDS	☐	☐	Thyroid Problems	☐	☐
Polio	☐	☐	**GASTROINTESTINAL**		
Rheumatic Fever	☐	☐	Stomach Ulcer	☐	☐
Tuberculosis	☐	☐	Gallstones	☐	☐
CARDIOVASCULAR			Liver Disease	☐	☐
High Cholesterol	☐	☐	**RENAL/GENITOURINARY**		
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Birth Defect of Heart	☐	☐	Kidney Stones	☐	☐
Heart Murmur	☐	☐	Prostate Problems	☐	☐
Pericarditis	☐	☐	Urinary Tract Infections	☐	☐
Heart Attack	☐	☐	**MUSCULOSKELETAL**		
Previous Stent or Angioplasty	☐	☐	Gout	☐	☐
Irregular Heart Beats	☐	☐	Arthritis	☐	☐
Peripheral Vascular Disease	☐	☐	Back Pain	☐	☐
PULMONARY			Hearniated Disc	☐	☐
Lung Disease	☐	☐	**HEMATOLOGIC/ONCOLOGY**		
Prior Pneumonia	☐	☐	Anemia	☐	☐
Exposure to Inhaling Hazardous Agent	☐	☐	Cancer - List Type	☐	☐
NEUROLOGIC			Bleeding Problems	☐	☐
Stroke/TIA	☐	☐	Blood Clots	☐	☐
Migraines	☐	☐			
Seizure Disorder	☐	☐			

PAST PATIENT HISTORY - PLEASE COMPLETE THE FOLLOWING TABLE		
	Health Problems	If deceased, age and cause of death
Mother		
Father		
Siblings		
Grandparents:		

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS OR OVER THE COUNTER MEDICATIONS AND DOSAGES					
Med Name	Dose	Frequency (# times per day)	Med Name	Dose	Frequency (# times per day)

Are there any medications which you stopped taking in the past month? ☐ Yes ☐ No

If you answered "yes", which medications have you stopped? ______________________

Are you currently taking Aspirin? ☐ Yes ☐ No How often? ______________________

Are you allergic to any medication? ☐ Yes ☐ No List what medication(s) ______________________

Describe the type of allergic reaction you had to this medication ______________________

SOCIAL HISTORY - PATIENT PLEASE ANSWER THE FOLLOWING QUESTIONS

Yes	No	
☐	☐	Have you ever smoked?
		If yes: # packs/day ________ # years smoked ________
☐	☐	Are you still smoking?
		If you have stopped smoking, when did you quit? ______________________
☐	☐	Do you drink alcohol? If yes, please list type and quantity: ______________________
☐	☐	Do you use recreational drugs? What type ______________________
☐	☐	Do you exercise? Type ______________ Miles ________ Times/day/week ________

Place of Birth: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

If surgery is planned, will you have help at home to assist in your recovery? ☐ Yes ☐ No

If no, what type of assistance do you feel that you may need? ______________________

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Current Occupation: ______________ If retired, from what? ______________

Have you recently traveled outside of the United States? ☐ Yes ☐ No

If you answered "yes", where did you travel to and when? ______________________