MID AMERICA HEART & LUNG SURGEONS

Patient to complete this information

Patient's Name _____ **Birth date** _____ **Today's date** _____

Referring Physician_____ **Primary Care Physician**_____

Age _____ **Occupation** _____ ☐ **Retired, how long**?_____

Prior operations

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____

Medications

Name	Dose
_____	
_____	
_____	
_____	

Have you had? ☐ Pneumonia ☐ Heart attack

☐ Kidney failure ☐ Rheumatic fever ☐ Hepatitis

☐ Cancer ☐ Ulcers ☐ Hiatal Hernia

☐ High Blood Pressure ☐ Gout ☐ Asthma

☐ Sleep Apnea ☐ Diabetes

Medication Allergies: _____

Latex Allergy? ☐ Yes ☐ No

Contrast Allergy? ☐ Yes ☐ No

Family History

Mother's age:____ If deceased, cause: _____ Father's age: ____ If deceased, cause: _____

Do you have a family history of? ☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Aortic Aneurysm

Personal History

Marital Status: ☐ Single ☐ Widowed ☐ Divorced ☐ Married, number of years _____ Number of children:_____

Tobacco use: ☐ Yes ☐ No ☐ Current smoker ☐ Past smoker Packs per day:_____ Year stopped ___ ☐ Chew

Alcohol use: ☐ Yes ☐ No ☐ 1 drink/week ☐ Daily

Patient to complete this information

Do you have any of the following symptoms or concerns?

GENERAL

Fever…….. ☐ NO ☐ Yes
Chills…….. ☐ NO ☐ Yes
Weight loss…….. ☐ NO ☐ Yes
If so how much?_____

SKIN

Rash..…… ☐ NO ☐ Yes
Itching..…… ☐ NO ☐ Yes
Easy bruising…… ☐ NO ☐ Yes

Head, Eyes, Ears

Headaches……..…… ☐ NO ☐ Yes
Dentures……..…….. ☐ NO ☐ Yes
Nose bleeds……..…… ☐ NO ☐ Yes
Glasses…….. ☐ NO ☐ Yes
Hearing loss…….. ☐ NO ☐ Yes
Cataracts…….. ☐ NO ☐ Yes

Chest/Respiratory

Cough..……..……... ☐ NO ☐ Yes
Shortness of breath…….. ☐ NO ☐ Yes
Coughing up blood…….. ☐ NO ☐ Yes
Tuberculosis……..…… ☐ NO ☐ Yes

Heart

Angina/Chest Pain..…… ☐ NO ☐ Yes
Passing out…….. ☐ NO ☐ Yes
Heart murmur……..…… ☐ NO ☐ Yes
Elevated cholesterol…….…… ☐ NO ☐ Yes
Palpitations……..……. ☐ NO ☐ Yes
Awakened at night short of breath…… ☐ NO ☐ Yes
Sleep on more than one pillow……..…… ☐ NO ☐ Yes
Ankle edema…… ☐ NO ☐ Yes

Gastrointestinal

Poor appetite…… ☐ NO ☐ Yes
Nausea……..…… ☐ NO ☐ Yes
Vomiting…… ☐ NO ☐ Yes
Constipation…….. ☐ NO ☐ Yes
Bloody stools…… ☐ NO ☐ Yes
Black stools…….. ☐ NO ☐ Yes
Diarrhea..…… ☐ NO ☐ Yes
Gallstones……..…. ☐ NO ☐ Yes
Jaundice…… ☐ NO ☐ Yes

OVER

Patient to complete this information

Do you have any of the following symptoms or concerns?

Urinary

Do you awake to urinate?……..	☐ NO	☐ Yes
If so how much? ☐ Once ☐ Twice ☐ Three or more times		
Painful urination……...	☐ NO	☐ Yes
Frequent urination..……	☐ NO	☐ Yes
Kidney stones…….……..	☐ NO	☐ Yes
Incontinence…….….	☐ NO	☐ Yes
Erectile dysfunction……..	☐ NO	☐ Yes
Blood in urine……	☐ NO	☐ Yes

Endocrine

Diabetes…….….	☐ NO	☐ Yes
Thyroid abnormality…..……..……	☐ NO	☐ Yes
Hot or cold intolerance…….……	☐ NO	☐ Yes

Hematologic

Bleeding tendencies……..…	☐ NO	☐ Yes
Anemia……..….	☐ NO	☐ Yes

Musculoskeletal

Arthritis……	☐ NO	☐ Yes
Calf, thigh pain with walking……	☐ NO	☐ Yes
Peripheral arterial disease……...	☐ NO	☐ Yes
Foot sores……..	☐ NO	☐ Yes
Varicose veins……	☐ NO	☐ Yes

Neuro-Psychologic

Stroke……..…..	☐ NO	☐ Yes
TIA……..……	☐ NO	☐ Yes
Seizures…….……	☐ NO	☐ Yes
Dizziness…….……..	☐ NO	☐ Yes
Depression…….	☐ NO	☐ Yes

Leave Blank For MLP use

Examination

(Check if normal, circle and explain, if abnormal)

Height_____Weight _____

Vital Signs: Pulse _____

Respirations _____ BP_____/_____

CONSTITUTIONAL:□ Well developed, well-nourished

□ NAD □ Caucasian □ AA □ Asian □male □female

SKIN: □ Warm □ Acyanotic

□ No mass/lesions □ other _____

HEENT:□ AT/NC □ PERRLA □ EOM's full

□ Conjunctiva pink □ Dentition good □ dentures

□ Other_____

NECK:□ Supple □ TML □ JVD □ Bruit □ Adenopathy

□ Thyroid abnormality □ Carotid upstroke normal

CHEST/RESPIRATORY: □ Symmetric ventilation

□ Clear to percussion & auscultation

□ Other_____

Leave Blank For Surgeon's use

History:

Examination

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HEART:□ Apical rate regular

□ Normal left ventricular impulse □ Rub

□ Murmur_____

ABDOMEN:□ Protuberant □ Scaphoid

□ Soft/Non-tender □ Mass □ Bowel sounds

□ Hepato-splenomegaly □ Normal aortic pulsation

□ Other_____

EXTREMITIES:□ FROM/No deformity

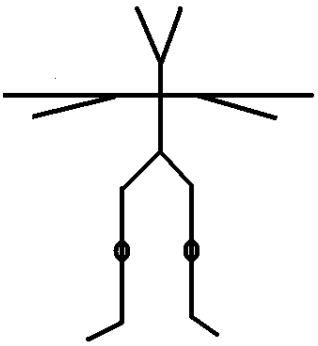
□ Strength/tone intact □ No edema

□ Other_____

NEURO-PSYCH: □ Oriented x 3 □ Normal affect

□ Motor/Sensory □ Cranial nerves

Pulses:



I have reviewed the ROS completed by

_____**on** _____

located in this chart.

Assessment and Plan:

Signature:_____

Date:_____

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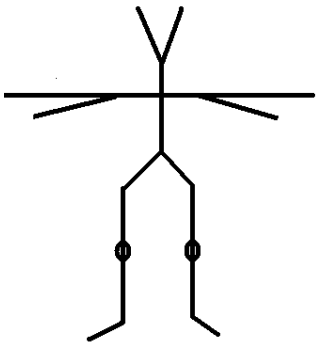

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_____**on** _____

located in this chart.

Assessment and Plan:

Physician Signature:_____

Date:_____