MID AMERICA
HEART & LUNG SURGEONS

Patient to Complete This Information

Patient's Name ________________________________ **Birth date** ______________ **Todays date** _________________

Referring Physician____________________________ **Primary Care Physician**_______________________________

Age ______ **Occupation** ____ ☐ **Retired, how long**? __________________

What problem brings you to see us today? ☐ **Follow Up** ☐ **New Patient**

____

____

Medications: Dosage Frequency

(or bring list to be copied)

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Name: ____

Medication Allergies: ____

____

Latex Allergy? ☐ Yes ☐ No **Iodine/Contrast Allergy?** ☐ Yes ☐ No

Will you accept blood products for surgery if needed? ☐ Yes ☐ No

Past Medical History:

☐ Heart attack
☐ Congestive Heart Failure
☐ Atrial Fibrillation
☐ High Blood Pressure
☐ Coronary Artery Disease
☐ Peripheral Vascular Disease
☐ Blood clot in leg (DVT)
☐ Pulmonary Embolus

☐ Sleep Apnea
☐ Pneumonia
☐ Kidney failure
☐ Rheumatic fever
☐ Asthma
☐ Thyroid Disease
☐ Hepatitis
☐ Cancer________________

☐ Diabetes
☐ Ulcers
☐ Hiatal Hernia
☐ Gout
☐ Other Illnesses___________
____

Prior operations:

Date: ________________Procedure:____

Date: ________________Procedure:____

Date: ________________Procedure:____

Date: ________________Procedure:____

Date: ________________Procedure:____

Date: ________________Procedure:____

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__________ ☐ Lung Disease

Other Illnesses____

Personal History

Tobacco Use: ☐ No ☐ Yes If yes: ☐ Current Smoker ☐ Former Smoker

Packs Per Day: ________ Year Stopped _________ How Long Have/Did You Smoke? ________

Chew Tobacco ☐ No ☐ Yes If yes: ☐ Current ☐ Former

Times Per Day: ________ Year Stopped _________ How Long Have/Did Chew? ________

Alcohol Use: ☐ Yes ☐ No ☐ #____ Drink(s) per Day / Week / Month (circle one)

Social History:

Marital Status: ☐ Single ☐ Widowed ☐ Divorced ☐ Married

Who Should Be Contacted in Case of Emergency? ______________________________Relationship? ______________

Phone Number: ________________________________

Do You Have Any of The Following Symptoms or Concerns?

GENERAL

Symptom	No	Yes
Fatigue	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Chills	☐ No	☐ Yes
Night Sweats	☐ No	☐ Yes
Weight Gain	☐ No	☐ Yes
If so, how much? ______________________		
Weight Loss	☐ No	☐ Yes
If so, how much? ______________________		

SKIN

Symptom	No	Yes
Bruising	☐ No	☐ Yes
Itching	☐ No	☐ Yes
Rash	☐ No	☐ Yes

HEAD, EYES, EARS, NOSE, THROAT

Symptom	No	Yes
Headache	☐ No	☐ Yes
Visual Changes	☐ No	☐ Yes
Wears glasses/contact lenses	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Hearing Loss	☐ No	☐ Yes
Nose Bleeds	☐ No	☐ Yes
Routine Dental Care	☐ No	☐ Yes
Dentures	☐ No	☐ Yes
Hoarseness	☐ No	☐ Yes
Sinusitis (Sinus Infections)	☐ No	☐ Yes

RESPIRATORY/BREATHING

Symptom	No	Yes
Shortness of Breath (at rest)	☐ No	☐ Yes
Cough	☐ No	☐ Yes
Coughing up blood	☐ No	☐ Yes
History of TB/ Exposure	☐ No	☐ Yes
Sleep Apnea	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

HEART

Symptom	No	Yes
Chest Pain	☐ No	☐ Yes
Shortness of Breath (with exertion)	☐ No	☐ Yes
Shortness of Breath (at night)	☐ No	☐ Yes
Discomfort when breathing while lying flat	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Irregular Heart Beat	☐ No	☐ Yes
Murmur	☐ No	☐ Yes
Ankle Swelling	☐ No	☐ Yes
Fainting	☐ No	☐ Yes

GASTROINTESTINAL

Symptom	No	Yes
Anorexia	☐ No	☐ Yes
Indigestion	☐ No	☐ Yes
Nausea	☐ No	☐ Yes
Vomiting	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Difficult/Painful Swallowing	☐ No	☐ Yes
Vomiting of Blood	☐ No	☐ Yes
Bloody Stools	☐ No	☐ Yes
Dark Stools	☐ No	☐ Yes

Do You Have Any of The Following Symptoms or Concerns?

URINARY

Do you urinate frequently? ☐ No ☐ Yes
Incontinence ☐ No ☐ Yes
Painful urination ☐ No ☐ Yes
Do you awake at night to urinate? ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Date of Last Menstrual Period (women):_________________ ☐ No ☐ Yes
Erectile dysfunction (men) ☐ No ☐ Yes

MUSULOSKELETAL

Calf, Thigh Pain with Walking ☐ No ☐ Yes
Arm Weakness ☐ No ☐ Yes
Muscle Pain ☐ No ☐ Yes
Arthritis ☐ No ☐ Yes
Varicose Veins ☐ No ☐ Yes
Foot Sores ☐ No ☐ Yes
Gout ☐ No ☐ Yes
Leg Weakness ☐ No ☐ Yes

NEUROLOGICAL

Altered Memory ☐ No ☐ Yes
Dizziness ☐ No ☐ Yes
Stroke ☐ No ☐ Yes
TIA ☐ No ☐ Yes
Seizure Disorder ☐ No ☐ Yes
Numbness/ Tingling ☐ No ☐ Yes

PSYCHIATRIC

Anxiety ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Insomnia ☐ No ☐ Yes

ENDOCRINE

Heat Intolerance ☐ No ☐ Yes
Cold Intolerance ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes
Thyroid Abnormalities ☐ No ☐ Yes
Hormone Therapy ☐ No ☐ Yes

HEMATOLOGY

Anemia ☐ No ☐ Yes
Easy Bruising ☐ No ☐ Yes
Easy Bleeding ☐ No ☐ Yes
Previous Transfusion ☐ No ☐ Yes
History of Malignancy ☐ No ☐ Yes
Will allow blood products? ☐ No ☐ Yes

<u>FOR OFFICE USE</u>

Height______________________________
Weight______________________________
BP (Right)___________________________
BP (Left)____________________________

Respirations_________________________
Pulse________________________________
O2__________________________________
Temp________________________________