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

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

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

HEAD, EYES, EARS, NOSE, THROAT

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

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

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

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

FOR OFFICE USE

Height_____
Weight_____
BP (Right)_____
BP (Left)_____
Respirations_____
Pulse_____
O2_____
Temp_____