West Georgia Cardiology
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Cardiology History Form

Name:_____Date:_____
Referring Physician_____Date of Birth: _____
Self-Referral _____ Yes _____ No

Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for you

General		**Cardiovascular**		**Gastrointestinal**	
Recent weight change		Chest pain with activity		Rectal bleeding	
Fatigue		Heart skips beats		Blood in stool	
Head and Neck		Heart beats too fast		Loss of appetite	
Swelling in neck		Passing out spells		Chronic abdominal pain	
Pain or stiffness in neck		High blood pressure		Nausea or vomiting	
Skin		Heart murmur		Vomiting of blood	
Rash, dryness, itching		Bad heart valve		**Psychiatric**	
Change in nails or skin color		Rheumatic Fever		Depression	
Bleeding, bruising tendencies		Feet or ankle swelling		Anxiety	
Eyes		Short of breath at rest		Nervous breakdown	
Double, failing vision		Short of breath with exercise		Alcohol problems	
Dry eyes		Short of breath lying down		Physical, verbal, sexual abuse	
Pain or light sensitivity		**Lungs**		Drug problems	
Ears, Nose, Mouth		Cough			
Earache or drainage		Cough with sputum or blood			
Hearing loss		Wheezing			
Ringing in ears		**Musculoskeletal**			
Dentures		Swollen or red joints			
Sores in mouth		Arm or leg weakness			
		Leg cramps			
Endocrine		Difficulty in walking			
Night sweats		**Neurologic**			
Excessive thirst		Lightheadedness or dizziness			
		Speech disturbances			
Genitourinary		Convulsions or seizures			
Burning or painful urination		Numbness or tingling			
Frequent urination		Frequent headaches			
Blood in urine		Memory loss			
Irregular menses, female only		Paralysis or weakness			
		Sleep disorders			

Past and Family Medical History: Please check if you or your family have ever had any of the following

	You	**Family**		**You**	**Family**		**You**	**Family**
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Blood Disorders			Vision Problems		
Renal Disease			Lupus			Hearing Problems		
Ulcerative Colitis			Stroke			Glaucoma		
Other			Other			Other		

Please list all allergies including medications, food, and environmental

Medication, Food, Other	Reaction

Please list any recent hospitalizations, and surgeries, and an approximate date of hospitalization

Date	Reason for hospitalization or surgery

Social History:

Marital Status: Single D Divorced D Married D Widow/Widower D Other D

Who lives at home with you? _____

Who to contact in case of an emergency and phone number: _____

Current Occupation/Employer: _____ Type of work: _____

Do you smoke? Yes D No D If yes, how many packs per day? _____

Did you smoke? Yes D No D If yes, when did you quit? _____

Do you drink alcohol? Yes D No D

If yes, indicate on average how much and check day, week, or month

_____Beer per:	Day	Week	Month
_____Glasses of wine per:	Day	Week	Month
_____Mixed drinks per:	Day	Week	Month

Do you have any cultural or religious requirements regarding healthcare? Yes _____ No _____

Patient Signature _____ Date: _____

Medical Assistant Initials _____ Date: _____