Florida
Cardiopulmonary Center
Central Florida Cardiovascular Consultants, PL

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Please fill out all pages as completely as possible.

NAME ________________________________ Date of Birth _______________ Age________

DATE ______________ Referring Physician ______________________

CHIEF COMPLAINTS:

____
____
____

PAST MEDICAL HISTORY (Have you had these?)

CARDIAC:

Hypertension	Yes _____	No _____
Heart attack	Yes _____	No _____
Congestive heart failure	Yes _____	No _____
Heart catheterization	Yes _____	No _____
Heart bypass surgery	Yes _____	No _____
Stress test	Yes _____	No _____
Echocardiogram	Yes _____	No _____

ENDOCRINE

Diabetes	Yes _____	No _____
High cholesterol	Yes _____	No _____
Hypothyroidism	Yes _____	No _____
Hyperthyroidism	Yes _____	No _____

NEUROLOGICAL

Stroke	Yes _____	No _____
Epilepsy	Yes _____	No _____

VASCULAR

Peripheral Vascular Disease	Yes _____	No _____
Carotid Artery Disease	Yes _____	No _____

RESPIRATORY:

Bronchial Asthma	Yes _____	No _____
Pneumonia	Yes _____	No _____
Emphysema	Yes _____	No _____
Lung cancer	Yes _____	No _____

GASTROINTESTINAL :

Peptic Ulcer Disease	Yes _____	No _____
Hepatitis	Yes _____	No _____
Irritable Bowel Syndrome	Yes _____	No _____
Ulcerative Colitis	Yes _____	No _____
Crohn's Disease		

UROLOGICAL

Kidney Stones	Yes _____	No _____
Chronic Kidney Disease	Yes _____	No _____
Benign Prostatic Hypertrophy	Yes _____	No _____

OTHERS:

Arthritis	Yes _____	No _____
Bleeding disorders	Yes _____	No _____
Cancer	Yes _____	No _____

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LIST ANY OTHER DISEASES:

____

____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

____

____

____

ALLERGIES *(*To the following medications, please check)

Penicillin ________________ Sulfa _______________ Aspirin _____________ Shellfish _____________ IV Dye _____________

Other medications: Please name ____

Please specify reaction to above medications: ____

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

FAMILY MEDICAL HISTORY (Has any blood relative ever had?)

YES	NO		WHO	YES	NO		WHO
____	____	Diabetes	__________________ ;	____	____	Cancer	___________________
____	____	High Blood Pressure	__________________ ;	____	____	Stroke	___________________
____	____	Heart Disease	__________________ ;	____	____	Abnormal Bleeding	__________________

759 Harley Strickland Blvd., Orange City, FL 32763
Phone: 386-456-0300

Fax: 386-456-0303
www.FLHeartLung.com

1319 S International Pkwy. Suite 1171, Lake Mary, Florida 32746
Tel: 407-268-3660

SOCIAL HISTORY

Female Patients: Are you pregnant or do you think you are pregnant? Yes ______ No ______

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Tobacco use:

Are you currently using tobacco? Yes ____ No ____ # packs per day __________ for how many years _______ How long after you wake up do you smoke your first cigarette?____________________

How ready are you to quit? (check one) _______Ready to quit? _______Thinking about quitting? ______Not ready to quit?

Did you use tobacco in the past? Yes ____ No ____ # packs per day __________ for how many years?________________

Date you quit ______________________________

Alcohol Use

Do you use alcohol regularly? Yes_______ No_______ how much per day _______ for how many years?__ Did you use tobacco in the past? Yes ____ No _____ How much per day __________ for how many?________________________
Date you quit ______________________________

Exercise:

Do you exercise regularly? Yes ________No ________. How much?____________

REVIEW OF SYSTEMS

CARDIAC

Shortness of breath	Yes _____	No _____
Chest pain	Yes _____	No _____
Heart Palpitations	Yes _____	No _____
Dizziness, fainting	Yes _____	No _____
Ankle Swelling	Yes _____	No _____

ENDOCRINE

Excessive Thirst	Yes _____	No _____
Increased urination	Yes _____	No _____
Heat or cold intolerance	Yes _____	No _____
Rising to Void, more than once per night	Yes _____	No _____

NEUROLOGICAL

Severe Headaches	Yes _____	No _____
Confusion	Yes _____	No _____
Weakness in Arm/Leg	Yes _____	No _____
Transient Blindness	Yes _____	No _____

VASCULAR

Calf Pain on Ambulation	Yes _____	No _____
Numbness/Tingling in Feet	Yes _____	No _____

RESPIRATORY

Cough	Yes _____	No _____
Spitting of blood	Yes _____	No _____
Wheezing	Yes _____	No _____

GASTROINTESTINAL

Abdominal pain or heartburn	Yes _____	No _____
Nausea, vomiting	Yes _____	No _____
Diarrhea	Yes _____	No _____
Constipation	Yes _____	No _____
Blood in Stool	Yes _____	No _____

GENERAL REVIEW

Weight change	Yes _____	No______
Extreme Fatigue	Yes _____	No _____
Fever	Yes _____	No _____
Joint pains	Yes _____	No _____
Excessive bruising	Yes _____	No _____
Impaired sight	Yes _____	No _____
Nose bleed	Yes _____	No _____
Anxiety	Yes _____	No _____