Florida Cardiopulmonary Center

Central Florida Cardiovascular Consultants, PL

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Board Certified Cardiovascular Diseases & Interventional Cardiology
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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 00	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______

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	Yes______	No______

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Hyperthyroidism Yes_____ No_____

NEUROLOGICAL

Stroke Yes_____ No_____

Epilepsy Yes_____ No_____

VASCULAR

Peripheral Vascular Disease Yes_____ No_____

Carotid Artery Disease Yes_____ No_____

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_____

LIST ANY OTHER DISEASES:

____

____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

____

____

____

<u>ALLERGIES</u> (To the following medications, please check)

Penicillin ____________________ Sulfa __________ Aspirin_____________ Shellfish _____________ IV Dye _____________

Other medications: Please name____

Please specify reaction to above medications:______________________________________

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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	________________

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 ______________________________

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Florida Amputation Prevention Institute

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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	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____