San Tan Cardiovascular Center LLC

Phone: (480) 632-1577 **Fax:** (480) 632-1574

Mesa
6959 E Rembrandt Ave
Suite 117
Mesa, AZ 85212

Gold Canyon
6740 S. Kings Ranch Road
Suite 103
Gold Canyon, AZ 85118

Chandler
3980 E. Riggs Rd
Building 4 Suite 2
Chandler, AZ 85249

NEW PATIENT MEDICAL HISTORY FORM

Date:- ____________________________

Please complete the following questions for your physician's review.

Name:____

First *Middle* *Last*

Do you have a living will? Yes__ No__ If yes, please provide us with a copy.

How did you find out about us? Physician referral __Relative or friend __Insurance __

Website __Hospital __ Phone book __

Others □ (please include) ____

Do you want your records sent to your physician? Yes __ No__

Physician's name:____

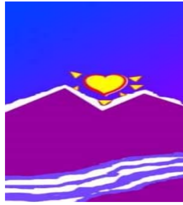
Address: ____

MEDICAL HISTORY

Reason for today's visit: establish with cardiologist __ specific complaint or health concern __ second opinion __ previous patient from ACS D Other __ (please specify)

Past Medical History:

Condition	Yes	No	Condition	Yes	No
Diabetes	**Yes** __	**No** __	Hypertension	**Yes** __	**No** __
Stroke	**Yes** __	**No** __	Mini stroke	**Yes** __	**No** __
Congestive heart failure	**Yes** __	**No** __	Heart valve problems	**Yes** __	**No** __
Rheumatic heart disease	**Yes** __	**No** __	High cholesterol	**Yes** __	**No** __
Irregular heart rhythm or arrhythmia	**Yes** __	**No** __	Aneurysm	**Yes** __	**No** __
Pacemaker	**Yes** __	**No** __	Pneumonia	**Yes** __	**No** __
COPD	**Yes** __	**No** __	Sleep apnea	**Yes** __	**No** __
Home oxygen use	**Yes** __	**No** __	Asthma	**Yes** __	**No** __
Arthritis	**Yes** __	**No** __	Osteoporosis	**Yes** __	**No** __
Cancer (specify) ______________	**Yes** __	**No** __	Thyroid disease	**Yes** __	**No** __
Anemia	**Yes** __	**No** __	Bleeding disorders	**Yes** __	**No** __
Blood clots	**Yes** __	**No** __	Liver disease or hepatitis	**Yes** __	**No** __
Stomach ulcers	**Yes** __	**No** __	Polyps or acid reflux	**Yes** __	**No** __
Diverticulitis or diverticulosis	**Yes** __	**No** __	Hernias	**Yes** __	**No** __
Infections (specify) ______________	**Yes** __	**No**__	Kidney disease	**Yes** __	**No** __
Prostate disease	**Yes** __	**No** __	Dementia	**Yes** __	**No** __
Depression	**Yes** __	**No** __			
Other	**Yes** __	**No** __	(specify) ______________		



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Childhood diseases:

Measles Yes __ No __ Mumps Yes __ No __ Rubella (German measles)
Chickenpox (varicella)Yes __ No Others (please include) ______________________
____

PAST SURGICAL HISTORY:

Heart surgery (bypass) Yes __ No __ Valve surgery Yes __ No __ Tumor removal Yes __ No __
Cardiac birth defect surgery Yes __ No __ Angioplasty and/or stents Yes __ No __
Pacemaker (defibrillators) Yes __ No __ Carotid surgery Yes __ No __
Aneurysm repair surgery Yes __ No __ Others ____

Family History:

Hypertension Yes __ No __ Diabetes Yes __ No __ Heart attack Yes __ No __
Sudden death Yes __ No __ Obesity Yes __ No __ High cholesterol Yes __ No __
Stroke Yes __ No __ Bleeding or blood clotting abnormalities Yes __ No __
Others

RISK FACTORS:

Diabetes Yes __ No __ Smoking (__ packs per day) ____years smoked Yes __ No__
High cholesterol Yes __ No __ Hypertension Yes __ No __ Peripheral arterial disease Yes __ No __
Alcoholism Yes __ No __

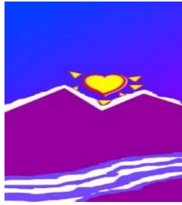
Social History:

Occupation ____
Marital status Yes __ No __ Exercise habits Yes __ No __ Sexually active Yes __ No __
Tobacco use Yes __ No __ Excessive exposure at home or work:
Caffeine use Yes __ No __ Noise Yes __ No __ Fumes Yes __ No __
Alcohol use Yes No __ Solvents Yes __ No __ Dust/airborne pollutants Yes __ No __
Recreational Drug use Yes __ No __ Recent travel outside of country Yes __ No __

Medications:	How Long have you been on it?

Allergies (list all medications that you are allergic to and what your reaction is):

____
____



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Other allergies: (tape, environmental substances, dye, etc.)

____
____
____

Recent Immunizations:

__Pneumovax __ Hepatitis A __ Hepatitis B __ Shingles __ HPV __ Influenza
__Others ____

__ Recent hospitalizations within the past 2 years / reason for hospitalization:______________________________

Review of Systems:

GENERAL:

__ Fever
__Night sweats
__Chills
__Weakness
__Fatigue
__Sensitivity to heat or cold
__ Weight gain of more than ten pounds in the past one year
__ Weight loss of more than ten pounds in the past one year
__ Loss in height of more than two inches

RESPIRATORY:

__Cough
__Chest pain
__ Shortness of breath
__ with or without exertion
__Wheezing
__Coughing up blood

CARDIOVASCULA:

__Chest pain
__at rest
__with exertion
__ SOB at rest
__Palpitations
__ Leg or hip pain on walking
__ on standing up
__ SOB with exertion
__Passing out spells
__Feeling faint
__Dizziness
__Leg or extremity swelling

GASTROINTESTINAL:

__Nausea
__Vomiting
__Vomiting blood
__Heart burn
__Diarrhea
__ Blood in stool
__Black stool
__Loss of appetite
__Abdominal pain
__Indigestion
__Hemorrhoids
__Pain while swallowing

NEUROLOGIC:

__Blurred vision
__Double vision
__ Blindness
__Slurred speech
__Loss of memory
__Seizures
__Weakness of body parts
__Numbness or tingling
__Difficulty swallowing
__Difficulty in equilibrium
__Instability while walking
__Headache

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GENITOURINARY:

__Frequent urination
__Blood in urine of urine
__Dark urine
__Pain/burning w/urination
__ Vag. discharge or abn. bleed
__ Inability of void urine completely
__ Freq. getting up at night to urinate
__ Inability to achieve/maintain erection
__ Lack of libido
__ Dribbling
__ Irregular menses
__ Painful periods

PSYCHIATRIC: __Depression __Anxiety __Excess stress __Irritability __Memory loss

SKIN: __ Abnormal skin growth or discoloration __Rash