CARDIOLOGY SPECIALISTS
of Orange County

MEDICAL HISTORY

(To be filled in by patient)

NAME ______________________ DATE ______________ AGE ________

REASON FOR VISIT OR CHIEF COMPLAINT: ______________________

____

REFERRED BY: ______________________________

PRESENT ILLNESS: *(to be filled in by physician)*

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(To be filled in by patient)

I. Have you had any reactions, allergies or bad effects from any of the following:

	Yes	No		Yes	No
Serum	☐	☐	Aspirin	☐	☐
Penicillin	☐	☐	Morphine	☐	☐
Other antibiotics	☐	☐	Other drugs *(specify)* ______		
Codeine	☐	☐	______		
Sulfa Drugs	☐	☐	______		

II. Have you ever had any of the following: *(If Yes, please check)*

1. Measles ☐
2. Mumps ☐
3. Chicken pox ☐
4. Whooping cough ☐
5. Scarlet fever ☐
6. Diptheria ☐
7. Rheumatic fever ☐
8. Glaucoma ☐
9. Migraine headaches ☐
10. Stroke or paralysis ☐
11. Fits or epilepsy ☐
12. Cancer or tumor ☐
13. High blood pressure ☐
14. High cholesterol ☐
15. Heart attack ☐
16. Other heart disease ☐
17. Tuberculosis, asthma or emphysema ☐
18. Ulcer or colon problems ☐
19. Gallbladder disease ☐
20. Kidney or bladder problems ☐
21. Arthritis or gout ☐
22. Anemia ☐
23. Sugar diabetes ☐

Have you had illnesses other than those listed above? ☐ Yes ☐ No *(If Yes, please list)*

______ ______
______ ______
______ ______

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Relation	Age if living	If dead — cause of death	Age at death
Father			
Mother			
Brothers			
Sisters			
Wife or Husband			
Children Male			
Female			

IV. List any significant family illnesses other than listed above:

____

V. OPERATION: Have you had any surgical treatment or operations? *(If Yes, list below)*

____

VI. Have you had serious accidents or injuries? *(If Yes, list below)*

____

VII. Menstrual History:

1. Number of pregnancies? __________ 2. Number of living children __________
3. Did you have any miscarriages? __________ 4. If yes, how many? __________
5. Have your menstrual periods stopped? __________ When __________
6. Did you have any difficult deliveries? __________
7. Did you have heart or kidney trouble during pregnancy? __________

VIII. Habits:

Do you now or have you ever smoked? ☐ Yes ☐ No ☐ Cigars ☐ Cigarettes ☐ Pipe
If yes, how much ________ How long ________ *(years)* If you have stopped, how long ago ________ *(years)*

Do you follow a regular exercise program? __________

Do you drink alcoholic beverages? ☐ Never ☐ Occassionally ☐ Almost daily ☐ More than above

Do you drink coffee? ☐ Yes ☐ No ☐ Less than 5 cups per day ☐ More than 5 cups per day

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IX. Do you take any of the following medicines or drugs regularly?

Digitalis (Medicine for the heart)	☐	Insulin	☐
Anticoagulants	☐	Aspirin	☐
Diuretics (to remove fluid)	☐	Thyroid	☐
Tranquilizers	☐	Sleeping Pills	☐
Drugs to lower high blood pressure	☐	Nitroglycerine	☐

Please list all other medications currently taking ________________________________

____

Please bring all medications or current list to your appointment.

X. Have you ever had or do you now have any of the following: *(If Yes, please check)*

Headaches	☐	Hemorrhoids	☐
Dizziness or blackouts	☐	Rupture or hernia	☐
Goiter or thyroid trouble	☐	Blood in urine	☐
Hearing or ear condition	☐	Red blood or black tarry bowel movements	☐
Hay Fever	☐	Excessive thirst	☐
Eye or vision problems	☐	Trouble starting or stopping urine	☐
Frequent sore throats	☐	Frequent or painful urination	☐
Pain or difficulty in swallowing	☐	Skin cancer	☐
Frequent hoarseness	☐	Shingles more than once	☐
Chronic cough	☐	Alcoholism	☐
Coughed up blood	☐	Narcotic or drug habit	☐
Severe or recurrent pain in chest	☐	Car, air or sea sickness	☐
Pneumonia or pleurisy	☐	Tremor or palsy	☐
Heart murmer	☐	Difficulty sleeping	☐
Shortness of breath on climbing flight of stairs	☐	Frequent or terrifying nightmares	☐
Swelling of ankles	☐	Attempted suicide	☐
Irregular, palpitation or fast heartbeat	☐	Frequent depression	☐
Pain or cramps in legs with walking	☐	Urinate more than once a night	☐
Varicose veins or phlebitis	☐	Dribbling of urine	☐
Recent change in appetite	☐	Prostrate troubles	☐
Change in weight	☐	Disabling back pain	☐
Vomiting of blood	☐	Bone, joint or other deformity	☐
Frequent vomiting	☐	Neuritis	☐
Recurrent burning in stomach	☐	Pain after drinking alcohlic beverages	☐
Frequent diarrhea or constipation	☐	Blood disorder	☐
Yellow jaundice	☐	Chronic skin condition	☐
Chronic abdominal pain	☐	Ulcer of legs or feet	☐
Frequent belching or bloating	☐	Hives	☐

Are you on any special diet? *(Please specify)* ________________________________