Tampa General Medical Group

Cardiology Health Survey

Name: _____ Date of Birth: _____

SSN: _____ Birthplace: _____

REFERRING PHYSICIAN

Name: _____

Address: _____

_____

Phone: (____)-_____-_____

Fax: (____)-_____-_____

OTHER PHYSICIANS

Name: _____

Address: _____

_____

Phone: (____)-_____-_____

Fax: (____)-_____-_____

Please identify any medication allergies:_____

Please list your symptoms or problems:

1. _____
2. _____
3. _____
4. _____

What medications do you take?
Please include all current medications, including diet aids, herbs, over-the-counter drugs (aspirin, arthritis pain relievers, Tylenol, etc.), prescription drugs, oral contraceptives, recreational drugs, laxatives, tonics, vitamins, and other minerals.

Name of Medicine	Dose (mg)	How many times per day?

Past Medical History

Describe any previous surgery:
(Include childhood procedures such as tonsillectomy, broken bones, etc.)

Hospitalization	Reason	Month/Year

Have you had any of the following cardiac procedures?

Cardiac Stress Test	Where?	Month/Year
Cardiac Catheterization		
Chest CT Scan or MRI		
Heart Surgery/Lung Surgery		
Echocardiogram		
Pacemaker/Defibrillator		

Have you been diagnosed with any of the following medical illnesses? *See example:*

Condition	Date of Onset	Comments/Outcome
EXAMPLE: High Blood Pressure	1992	**Started on pills, pressure better**
Infectious Diseases		
Whooping cough		
Diphtheria		
Small pox		
Pneumonia		
Rheumatic fever		
AIDS		
Tuberculosis		
Meningitis		
Polio		
Syphilis		
Gonorrhea		
Lung Diseases		
Emphysema		
Asthma		
Hay fever		
Bronchitis		
Pneumonia		

Heart Diseases		
Heart attack		
Angina		
Murmur		
Valve problem		
Rhythm problem		
High blood pressure		
Atherosclerosis		
Heart failure		
Phlebitis		
Embolism		
Pacemaker		
Kidney Diseases		
Kidney failure		
Glomerulonephritis		
Pyelonephritis		
Polycystic kidney		
Cystitis		
Bladder infection		
Kidney infection		
Kidney stones		
Prostate disease		
Rheumatic Diseases		
Osteoarthritis		
Lupus		
Gout		
Rheumatoid arthritis		
Scleroderma		
Vasculitis		
Sciatica		
Bursitis		
Disc Disease		
Neurological Diseases		
Stroke		
TIA's		
Seizure		
Migraines		
Neuropathy		
Psychiatric problems		
Hyperlipidemia		
High cholesterol		
High triglyceride		
Endocrine Diseases		
Diabetes		
Thyroid disease		
Adrenal disease		
Gastrointestinal Diseases		
Reflux disease		
Ulcers		
Colitis		

Hemorrhoids		
Gall bladder disease		
Hepatitis		
Jaundice		
Cirrhosis		
Pancreatitis		
Diverticulitis		
Blood Diseases		
Anemia		
Leukemia		
Bleeding problem		
Clotting problem		
Eye Diseases		
Glaucoma		
Cataracts		
Retinal disease		
Skin Diseases		
Hives		
Eczema		
Psoriasis		
Cancer (List each kind.)		
Other diseases		

Have you received any of the following immunizations?:

Name of Vaccine			**Date (Year)**
Influenza (flu)	YES ___	NO ___	_____
Hepatitis A	YES ___	NO ___	_____
Hepatitis B	YES ___	NO ___	_____
Pneumovax	YES ___	NO ___	_____
Chicken pox	YES ___	NO ___	_____
Tetanus	YES ___	NO ___	_____

Family History:

Please describe any medical illnesses for your family. Please include the relationship to you and any known outcome (cured, died, had an operation, etc.) *See example:*

Relation	Illness	Outcome
EXAMPLE: Mother age 66, 1st sister age 40	***Breast Cancer***	***Both had operations to remove it.***
Breast cancer		
Colon cancer		
Heart disease		
High blood pressure		
Diabetes		
Kidney disease		
Mental emotional illness		
Stroke		
Seizures/epilepsy		
Alcohol or drug abuse		
Liver disease		
High cholesterol		
Thyroid disease		

Social History:

Who lives at home with you now? _____

Who would be available to help you in the event of a major operation or severe medical illness?

_____

Education *(check)*: High School ☐ Tech School ☐ College ☐ Grad School ☐

Employment *(check all that apply)*: Housewife ☐ Student ☐ Disabled ☐ Unemployed ☐

If disabled or unemployed, describe previous employment: _____

_____

Full-time ☐ Part-time ☐ Nature of employment:_____

Family *(check):* Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Children *(age and gender):*

_____

Smoking *(check or fill in all that apply)*:

Never Smoked _____ Smoke Now - # of packs per day _____

Quit smoking (date) _____

½ Pack/day ___ 1 Pack/day ___ 2 Packs/day ___ I have smoked _____ years.

Alcohol *(check or fill in all that apply):*

Never drank _____ Started drinking alcohol at what age? _____

Quit drinking (date) _____

Did you drink every day? _____ How much/how often? _____

Do you drink alcohol now? _____

Do you drink every day? _____ How much/how often? _____

Exercise:

Do you exercise? _____ How often? _____

Have you ever taken birth control? _____

Are you on a special diet? _____ If so, what kind?

_____

Review of Systems:

Please indicate (check) if you have experienced any of the following symptoms or signs:

General: ___ Weight gain ___ Weight loss ___ Weakness ___ Fatigue ___ Fever ___ Other

Eyes: ___ Pain ___ Redness ___ Tearing ___ Dryness ___ Double vision ___ Glaucoma ___ Cataracts ___ Glasses ___ Other

Ears: ___ Itching ___ Vertigo ___ Infections ___ Earaches ___ Discharge ___ Abnormal hearing ___ Tinnitus (ringing) ___ Other

Nose: ___ Frequent colds ___ Stuffiness ___ Bleeding ___ Discharge ___ Frequent sinus infections ___ Other

Mouth: ___ Gum bleeds ___ Sore throats ___ Tongue sores ___ Hoarseness ___ Other

Cardiac: ___ Chest pain ___ Murmur ___ Dyspnea (shortness of breath)
___ Shortness of breath when supine ___ Rheumatic fever
___ Edema ___ Abnormal heart test
___ Palpitations ___ Other heart problems
___ Leg pain when walking ___ Other

Pulmonary: ___ Cough ___ Sputum ___ Shortness of breath
___ Bronchitis ___ Emphysema ___ Bloody cough ___ TB
___ Wheezing ___ Asthma ___ Pneumonia ___ Pleurisy
___ Other lung disease

Gastro ___ Constipation ___ Nausea ___ Black stool ___ Indigestion
-Intestinal ___ Swallowing problem ___ Belching/bloating ___ Heartburn
___ Vomiting ___ Diarrhea often ___ Flatulence
___ BM habit change ___ Rectal bleeding ___ Abdominal pain ___ Hepatitis
___ Vomiting blood ___ Other

Skin ___ Rashes ___ Sore ___ Dryness ___ Hair loss
___ Lumps ___ Itching ___ Color change ___ Nail change
___ Other

Breast ___ Lumps ___ Discharge ___ Discomfort ___ Self-exams
___ Other

Neurological: ___ Migraines ___ Headaches ___ Weakness ___ Numbness
___ Tingling ___ Tremors ___ Fainting ___ Seizures
___ Vertigo ___ Other

Psychiatric: ___ Anxiety ___ Depression ___ Tension ___ Bipolar
___ Nervousness ___ Memory loss ___ Libido loss
___ Schizophrenia ___ Other

Genito- ___ Urgency ___ Painful urination ___ Incontinence ___ Sores
Urinary ___ Painful menses ___ Venereal disease ___ Post menopause ___ Hesitancy
___ Frequent urination ___ Decreased stream ___ Painful intercourse
___ No menses ___ Birth control use ___ Urination at night
___ Blood in urine ___ Kidney stones ___ Other

Blood/	___ Anemia	___ Bruising	___ Thin blood	___ Leukemia
Lymphatic	___ Transfusions	___ Enlarged nodes		
Bones/	___ Joint pain	___ Stiffness	___ Arthritis	___ Backache
Muscles	___ Swelling	___ Gout	___ Other	
Endocrine	___ Heat tolerance	___ Cold intolerance	___ Thyroid problem	___ Diabetes
	___ Thirst	___ Frequent urination	___ Sweating	
	___ Frequent hunger	___ Other		

Chest Pain History *(check all that apply):*

Do you have any significant episodes of pain, aching, tightness, or discomfort in the chest?	Yes ___	No ___
Does the discomfort occur in the back, jaw, and shoulder or arm too?	Yes ___	No ___
Is it related to exertion?	Yes ___	No ___
Can excitement, emotion, or a meal precipitate such an episode?	Yes ___	No ___
Does rest typically relieve such an episode?	Yes ___	No ___
Have any of the episodes been such that rest or nitroglycerin did not bring relief in the typical manner?	Yes ___	No ___
Did you get medical attention in connection with an episode of pain, aching, etc. during this period?	Yes ___	No ___
Do you have discomfort at rest?	Yes ___	No ___
Do you have discomfort that wakes you up in the night?	Yes ___	No ___

What has been the longest duration of such an episode? _____

How many nitroglycerines do you take per week? _____

Please mention any other symptoms or illnesses not checked above:

_____

_____

_____

_____

_____

_____