Midwest Cardiovascular Research Foundation

Patient Medical History

*PLEASE COMPLETE THIS FORM BEFORE YOUR APPOINTMENT.

Date of Appointment:_____

Patient Name:_____ **Date of Birth:**_____

Preferred Pharmacy: ***Name and address***_____

_____

List ALL medications: ***Indicate exact name, how often taken,and how much is taken***

_____

_____

_____

_____

Primary Care Physician: ***Address and phone number***_____

_____

ALLERGIES: ***Drug/medication allergies***

_____

_____

Past history

Medical*:** ***Please √ any of the following along with date

	Hospitalizations Date(s):		Anemia Date(s):		Arrythmias Date(s):		Depression Date(s):
	Cancer Date(s):		Chest Pain/Pressure Date(s):		COPD Date(s):		Dizziness Date(s):
	Deep Vein Thrombosis Date(s):		Fractures Date(s):		Headaches Date(s):		Heart Problems Date(s):

	High Cholestrol Date(s):		Blod Transfusions Date(s):		Hyperthyroidism Date(s):		Hypothyroidism Date(s):
	Injuries Date(s):		Obesity Date(s):		Peripheral Artery Disease Date(s):		Pulmonary Problems Date(s):
	Seizures Date(s):		Tuberculosis Date(s):		Stroke/TIA Date(s):		Other Date(s):
	Other Date(s):		Other: Date(s):		Other Dates(s):		Other Date(s):

SURGERIES OF ANY KIND:

TYPE:	DATE:

Family History: *Please include cardiac/vascular history; heart attack, congenital heart probems, arrhythmia, congestive heart failure, stroke, stents in legs or heart, pacemaker, cancer, diabetes etc.*

Family History of Coronary Disease before 60 years old? ☐Yes ☐No Adopted? ☐Yes

Member	Living	Deceased	Age	History	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

SOCIAL HISTORY:

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other

Children: ☐Yes, Daughters (#)____ Sons (#)____ ☐No

Employed: ☐Yes Occupation_____ ☐No ☐Retired ☐Disabled

Diet: ☐Regular ☐Special_____

Exercise: ☐Doesn't exrcise ☐Daily exercise ☐A couple times a week ☐Once a week ☐Unable to due to health condition. ☐Other

Tobacco Use: ☐Never ☐Yes, Please continue filling out the next section:

*Tobacco Products Used: ☐Cigarettes ☐Cigars ☐Pipe ☐Chewing ☐Vaping

How many per day:_____ Number of years used:_____ Age Started:_____

Age Stopped:_____ Year Quit:_____

Alcohol Consumption: ☐Yes ☐No If yes, type and amount_____

Street Drug Use: ☐Yes ☐No

Caffeine Consumption: ☐Yes ☐No If yes, type and amount_____

REVIEW OF SYSTEMS: *Please √ only what is a current or ongoing problem.*

Recent Weight Gain		Cardiovascular problems		Fever		Visual Changes		Hearing Loss	
Snoring		Coughing up Blood		Short of Breath		Nausea		Reflux/ Heartburn	
Bleeding		Blood in Urine		Night Time Urination		Dizziness		Memory Concerns	
Seizures		Depression		Hallucinations		Anxiety		Chronic Anemia	
Rash		High Blood Pressure		Low Blood Pressure		Swelling of the neck (goiter)		Tremors	
Hot Flashes		Non healing skin sores		Joint Pain		Muscle Aches		Neurolgical Problems	
Other:		Other:		Other:		Other:		Other:	

Exercise Preparticipation Health Screening: *Please read the 7 questions below carefully and answer each one honestly: √ yes or No.*

	YES	NO
1.) Has your doctor ever said that you have a heart condition ☐ or High blood pressure ☐?		
2.) Do you feel pain in your chest at rest, during your daily activity of living, or when you do physical activity?		
3.) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? (Please answer no if your dizziness was associated with over-breathing (including during vigorous exercise).		
4.) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? Please list condition(s) here:		
5.) Are you currently taking prescribed medications for a chronic medical condition? Please list condition(s) and medication(s) here:		
6.) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer no if you had a problem in the past, but it *does not limit your current ability* to by physically active. Please list condition(s) here:		
7.) Has your doctor ever said that you should only do medically supervised physical activity?		

Patient Signature:_____

Date:_____