Columbia Heart

NEW PATIENT HISTORY & PHYSICAL

PATIENT NAME:	DATE:
REFERRING PHYSICIAN:	DOB:
REASON FOR VISIT:	
CURRENT MEDICATIONS:	
ALLERGIES:	

FAMILY MEDICAL HISTORY (INDICATE FAMILY MEMBER)

Asthma Yes ☐No☐	High Blood Pressure Yes ☐No☐	Cancer/Breast Cancer Yes ☐No☐	Thyroid Disease Yes ☐No☐
Kidney Disease Yes ☐No☐	Tuberculosis Yes ☐No☐	Seizures Yes ☐No☐	Diabetes Yes ☐No☐
Heart Disease Yes ☐No☐	Congestive Heart Failure Yes ☐No☐	COPD Yes ☐No☐	Peripheral Vascular Disease Yes ☐No☐

PAST MEDICAL HISTORY – DO YOU NOW OR HAVE YOU EVER HAD:

Asthma Yes ☐No☐	Heart Attack Yes ☐No☐	Hepatitis Yes ☐No☐	Stomach Disease /Peptic Ulcer Yes ☐No☐
Bleeding Disorder Yes ☐No☐	Pneumonia Yes ☐No☐	High Blood Pressure Yes ☐No☐	Tuberculosis Yes ☐No☐
Seizures Yes ☐No☐	Cancer/Breast Cancer Yes ☐No☐	Thyroid Disease Yes ☐No☐	Lung Disease Yes ☐No☐
Diabetes Yes ☐No☐	Kidney Disease Yes ☐No☐	Sleep Disorders Yes ☐No☐	Liver Disease Yes ☐No☐
Transfusion Yes ☐No☐	Coronary Artery Disease Yes ☐No☐	Congestive Heart Failure Yes ☐No☐	COPD Yes ☐No☐
Hospitalizations/Operations: Please list any hospitalizations or surgeries:			

PRESENT MEDICAL HISTORY – DO YOU CURRENTLY HAVE:

HEENT

Painful Sinuses Yes ☐No☐	Difficulty Swallowing Yes ☐No☐	Voice Changes or Hoarseness Yes ☐No☐	Goiter or Thyroid Enlargement Yes ☐No☐

CARDIOVASCULAR

Murmur or Abnormal Heart Sound Yes ☐No☐	Smothering Spells at Night Yes ☐No☐	Valvular Heart Disease Yes ☐No☐	Irregular Heart Beat or Palpitations Yes ☐No☐
Rheumatic Fever Yes ☐No☐	Blood Clots Yes ☐No☐	Heart Enlargement Yes ☐No☐	Chest Pain Yes ☐No☐
Coronary Artery Disease Yes ☐No☐	Sleep on More Than One Pillow Yes ☐No☐	Leg Pain, Limiting Exercise Yes ☐No☐	Swollen Legs Yes ☐No☐
Ankle Edema Yes ☐No☐	Excessive Sweating Yes ☐No☐	Dizziness Yes ☐No☐	Other

RESPIRATORY

Difficulty Breathing Through Nose Yes ☐No☐	Frequent Cough Yes ☐No☐	Coughing up Blood Yes ☐No☐	Chronic Nasal Discharge Yes ☐ No☐
Night Coughs Yes ☐No☐	Frequent Pneumonia Yes ☐No☐	Phlegm or Sputum Yes ☐No☐	Other
Unusual Shortness of Breath Yes ☐No☐	Wheeze Yes ☐No☐	Emphysema Yes ☐No☐	

G.I./G.U.

Acid Reflux Yes ☐No☐	Difficulty or Excessive Urinating Yes ☐No☐	Peptic Ulcer Yes ☐No☐	Black or Tarry Bowel Movements Yes ☐No☐
Hiatal Hernia Yes ☐No☐	Frequent Bladder Infections Yes ☐No☐	Abdominal Pain Yes ☐No☐	Kidney Stones Yes ☐No☐
Blood in Bowel Movement Yes ☐No☐	Nausea/Vomiting Yes ☐No☐	Constipation/Diarrhea Yes ☐No☐	Weight Gain/Loss Yes ☐No☐

NEURO

History of Stroke Yes ☐No☐	Memory Loss Yes ☐No☐	Difficulty Speaking Yes ☐No☐	Difficulty Sleeping Yes ☐No☐
Frequent or Severe Headaches Yes ☐No☐	Head Injuries Yes ☐No☐	Seizures Yes ☐No☐	Other

ENDROCRINE/REPRODUCTIVE

Hair Loss Yes ☐No☐	Poor Wound Healing Yes ☐No☐	Easy Bruising Yes ☐No☐	Dizziness When Standing Yes ☐No☐
High Cholesterol or Lipids Yes ☐No☐	High Blood Sugar Yes ☐No☐	Low Blood Sugar Yes ☐No☐	Abnormal Glucose Tolerant Test Yes ☐No☐

HEMATOLOGICAL

High White Blood Cell Count Yes ☐No☐	Low White Blood Cell Count Yes ☐ No ☐	Frequent Skin Infections Yes ☐No☐	Bleeding Gums Yes ☐ No ☐
Swollen Lymph Glands Yes ☐No☐	HIV or AIDS Yes ☐ No ☐	Anemia (low hemoglobin) Yes ☐No☐	Other Yes ☐ No ☐

VASCULAR (DO YOU NOW OR HAVE YOU EVER HAD)

Aching, cramping or pain in arms, legs or buttocks when walking or exercise Yes ☐ No ☐	Numbness or tingling in arms or lower legs and feet Yes ☐No ☐	Fingers or toes pale, discolored or bluish Yes ☐No☐	Hands or feet cold to the touch Yes ☐ No ☐
Sores or ulcers on legs or feet that will not heal Yes ☐ No ☐	Pain in toes or feet at night Yes ☐No ☐	Varicose Veins Yes ☐No☐	More than 25 pounds overweight Yes ☐ No ☐

SLEEP (DO YOU NOW OR HAVE YOU EVER HAD THE FOLLOWING)

Loud Snoring Yes ☐No ☐	Gasping Episodes at night Yes ☐No ☐	Overweight/Obese Yes ☐No ☐	Trouble Concentrating Yes ☐No ☐
Excessive Daytime Sleepiness Yes ☐No ☐	Awaken Unrested Yes ☐No ☐	Morning Headaches Yes ☐No ☐	Night Sweats Yes ☐No ☐
Nod off while driving Yes ☐No ☐	Loss of Energy/Fatigue Yes ☐No ☐	Dry Mouth/Sore throat Yes ☐No ☐	Nighttime Urinating Yes ☐No ☐
Legs restless or Jerks Yes ☐No ☐	Frequent Awakenings Yes ☐No ☐	Insomnia Yes ☐No ☐	Other

SOCIAL HISTORY (DO YOU NOW OR HAVE YOU EVER USED)

Smoked Cigarettes Yes ☐ No ☐ How long: Have You Quit Yes ☐ No ☐ If yes, when:	Chewed Tobacco Yes ☐ No ☐ How long: Have You Quit Yes ☐ No ☐ If yes, when:	Alcohol Yes ☐ No ☐ How long: Have You Quit Yes ☐ No ☐ If yes, when:	Other:
How Much Exercise Do You Get: Light ☐ Moderate ☐ Heavy ☐			
Occupation:			

Comments or Additional Information:

The information provided is true and accurate to the best of my knowledge.

Signature _____ Date _____

I have reviewed and discussed the questionnaire with the patient.

Physician's Signature _____ Date _____

WHEN COMPLETE, PLEASE HAND DIRECTLY TO PHYSICIAN