NAME_____ DATE_____/____/_____
(First) (Middle) (Last) (Month) (Day) (Year)

DATA BASE

I. PERSONAL HISTORY

Have you ever had:	YES	NO
heart problem	(___)	(___)
heart murmur	(___)	(___)
chest pain	(___)	(___)
heart attack	(___)	(___)
pericarditis	(___)	(___)
heart infection (bacterial endocarditis)	(___)	(___)
cardiac catheterization	(___)	(___)
heart surgery	(___)	(___)
high blood pressure	(___)	(___)
vascular disease	(___)	(___)
stroke	(___)	(___)
varicose veins	(___)	(___)
vein stripping	(___)	(___)
phlebitis	(___)	(___)
blood clot in the lungs	(___)	(___)
bronchial asthma	(___)	(___)
lung disease	(___)	(___)
joint swelling	(___)	(___)
arthritis	(___)	(___)
rheumatic fever	(___)	(___)
auto wreck or other serious accident with chest trauma	(___)	(___)

Have you had repeated or prolonged exposure to substances that irritate the lungs?	(___)	(___)
If yes, specify:		
stone quarry dust	(___)	(___)
coal mine dust	(___)	(___)
asbestos	(___)	(___)
moldy wheat	(___)	(___)
beryllium	(___)	(___)
cotton mill dust	(___)	(___)
metal working	(___)	(___)

PERSONAL HISTORY (continued)

Have you ever had:

	YES	NO
thyroid disease_____	(___)	(___)
sugar diabetes_____	(___)	(___)
(cholesterol____) (triglycerides____) _____	(___)	(___)
glaucoma_____	(___)	(___)
stomach (____) or duodenal (____) ulcers _____	(___)	(___)
gastrointestinal bleeding _____	(___)	(___)
diagnosis of hiatus hernia_____	(___)	(___)
hepatitis_____	(___)	(___)
gall stones_____	(___)	(___)
pancreatitis _____	(___)	(___)
urinary infection_____	(___)	(___)
kidney disease _____	(___)	(___)
syphilis _____	(___)	(___)
pills (___) or shots (___) to eliminate fluid through the kidneys	(___)	(___)
blood pressure medications (___) blood thinning medications (___)		
insulin (___) or oral medication for diabetes (___) _____	(___)	(___)
Cortisone_____	(___)	(___)
Thyroid pills_____	(___)	(___)

List any serious infections you have had:

_____
_____
_____
_____

List any other surgical procedures not previously mentioned.

Procedure	Date

PERSONAL HISTORY (continued)

For women:	YES	NO
Are you pregnant now?	(___)	(___)
Do you use birth control pills?	(___)	(___)
Has your uterus been removed?	(___)	(___)
Have your ovaries been removed?	(___)	(___)
Date of last menstrual period		

II. ALLERGIES

Please list every drug or substance that causes an allergic reaction:

_____

_____

_____

	YES	NO
Are you allergic to dye or iodine?	(___)	(___)

III. REVIEW OF SYSTEMS (please check appropriate box below)

GENERAL:		
Do you have prolonged fever?	(___)	(___)
Do you have recent weight loss?	(___)	(___)
Do you feel tired in the mornings?	(___)	(___)
SKIN:		
Do you have skin problems?	(___)	(___)
EYES:		
Do you have decreased vision?	(___)	(___)
EAR/NOSE/THROAT:		
Do you have decreased hearing?	(___)	(___)
Do you have sinus trouble?	(___)	(___)
Do you have sore throats?	(___)	(___)
RESPIRATORY:		
Do you cough:	(___)	(___)
Do you wheeze?	(___)	(___)
Do you have bloody sputum?	(___)	(___)
Do you snore?	(___)	(___)
Do you quit breathing at night?	(___)	(___)

REVIEW OF SYSTEMS (continued)

CARDIOVASCULAR:

Do you have pain or discomfort in the jaw, neck, lower teeth, chest or arms during exercise, emotional upset, or at rest?	(___)	(___)
Does exercising, walking or climbing stairs make you short of breath?	(___)	(___)
Do you elevate your head with more than one pillow in order to breathe easier at night?	(___)	(___)
Have you been awakened from sleep with breathlessness or cough?	(___)	(___)
Do you have skipped beats?	(___)	(___)
Do you have rapid or slow heartbeats?	(___)	(___)
Do you have swelling of feet or ankles?	(___)	(___)
Do you have pain or tightness in your feet, calves, thighs, or buttocks while walking?	(___)	(___)
Do you have painful whitening of your fingertips when you are cold?	(___)	(___)

GASTROINTESTINAL:

Do you have frequent indigestion and/or abdominal pain?	(___)	(___)
Do you have nausea or vomiting?	(___)	(___)
Do you have bloody vomit?	(___)	(___)
Do you have black tarry or bloody stools?	(___)	(___)
Do you have recent appetite loss?	(___)	(___)

GENITOURINARY:

Do you have dark or bloody urine?	(___)	(___)
Do you have frequent urination at night?	(___)	(___)

OSTEOMUSCULAR:

Do you have leg cramps at night?	(___)	(___)
Do you have joint pain?	(___)	(___)
Do you have stiffness?	(___)	(___)

NEUROLOGICAL:

Do you develop numbness around the lips and in the fingers when you are short of breath?	(___)	(___)
Do you have fainting spells?	(___)	(___)
Have you had severe recurring headaches?	(___)	(___)
Have you had trouble with your coordination?	(___)	(___)
Have you had seizures?	(___)	(___)
Have you had paralysis?	(___)	(___)
Have you had trouble talking?	(___)	(___)
Have you had vertigo or dizziness?	(___)	(___)
Do you have trouble sleeping?	(___)	(___)

SOCIAL HABITS: YES NO

Do you use any form of nicotine product?_____ (___) (___)
Do you drink alcohol?_____ (___) (___)
Do you use recreational drugs?_____ (___) (___)
Do you drink coffee, tea, or caffeinated beverages?_____ (___) (___)
Do you follow a specific diet?_____ (___) (___)
LOW FAT? (___) LOW SALT? (___)
Do you have a regular exercise program?_____ (___) (___)

MEDICATIONS:
Please list all the medications you are currently taking.
Indicate the strength and dose schedule.

_____
_____
_____
_____
_____
_____
_____

IV. FAMILY HISTORY

Have any of your blood relatives had the following? YES NO
If so, specify whom:
Sudden death before age 50 _____ (___) (___)
who (relationship) _____
A heart attack before age 50 _____ (___) (___)
who (relationship) _____
High blood pressure _____ (___) (___)
who (relationship) _____
Diabetes _____ (___) (___)
who (relationship) _____
Rheumatic fever _____ (___) (___)
who (relationship) _____
High blood fat (cholesterol or triglycerides) _____ (___) (___)
who (relationship) _____
Thyroid disease _____ (___) (___)
who (relationship) _____
Glaucoma before age 50 _____ (___) (___)
who (relationship) _____
Become blind before age 50 _____ (___) (___)
who (relationship) _____
Become deaf before age 50 _____ (___) (___)
who (relationship) _____

FAMILY HISTORY (continued)	YES	NO
Cancer _____	(___)	(___)
who (relationship)_____		
Stroke_____	(___)	(___)
who (relationship) _____		
Tuberculosis_____	(___)	(___)
who (relationship) _____		
Epilepsy_____	(___)	(___)
who (relationship) _____		
Psychiatric illness_____	(___)	(___)
who (relationship) _____		

(RELATIONSHIP)	FIRST & LAST NAME	YEAR OF BIRTH	AGE	LIVING Y / N	LIST HEALTH PROBLEMS IF LIVING OR CAUSE OF DEATH IF DECEASED
Father					
Mother					
Brothers					
Sisters					

(CHILDREN)	FIRST & LAST NAME	YEAR OF BIRTH	AGE	LIVING Y / N	LIST HEALTH PROBLEMS IF LIVING OR CAUSE OF DEATH IF DECEASED
Son					
Son					
Son					
Daughter					
Daughter					
Daughter					