HENDRICK CLINIC

MEDICAL HISTORY FORM
PAGE 1 OF 3

NAME: _____DATE OF BIRTH: _____DATE:_____

PRIMARY CARE DOCTOR: _____

OTHER REFERRING DOCTOR: _____

REASON FOR VISIT/CHIEF COMPLAINT: (Please list the symptoms of the problem or problems which have caused you to come for cardiac evaluation. Please describe briefly your present illness.)_____

_____

_____

_____

Have you had any prior cardiac testing? Yes No If yes, what and when? _____

_____

COVID-19: (Please write Yes Or No next to each question)

Have you recently had a fever, cough, or Shortness of breath? _____

Have you recently traveled outside of your home area? _____

Have you been in contact with anyone who has a confirmed COVID-19? _____

Have you personally been tested or hospitalized for COVID-19? _____

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO
List Allergies:

_____

_____

ARE YOU SENSITIVE TO IODINE or SHELLFISH? YES NO

ROUTINE MEDICATIONS: (Please list and include DOSAGE & FREQUENCY and over the counter medications)

_____

_____

_____

FAMILY HISTORY:	**SERIOUS ILLNESS**	**IF DECEASED, CAUSE OF DEATH & AGE**
MOTHER	_____	_____
FATHER	_____	_____
BROTHER	_____	_____
SISTER	_____	_____

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NAME: _____DATE OF BIRTH: _____DATE:_____

PPLEASE WRITE YES OR NO AND/OR CHECK:

Diet: Low fat/cholesterol _____Diabetic _____ Weight loss_____ Renal_____ Low Carbohydrate_____
Vegetarian____ Other_____
Exercise: Sedentary_____ Physically unable to exercise_____ Occasional_____ Regular _____
Active_____ Other _____
Do you consume caffeine? _____ Former_____ Year quit _____ Frequency ____Amount_____
Have you ever smoked? _____ Cigarettes_____ Cigar _____Chew_____Other: _____
Packs per day_____ How long smoked ____ years _____months _____ other_____ Year quit _____
Have you ever used or abused drugs? _____ Former _____ If Yes, type_____ Frequency_____
Advance Directives: _____ DNR_____ Health Care Proxy _____ Living Will **_____ Date** made: _____

PAST MEDICAL HISTORY: (Please circle any of the following problems you have.)

CARDIO/VASCULAR

Blood clots
Carotid (neck)
Heart disease
Heart failure
Heart murmur
High cholesterol
Hypertension
Peripheral (legs)

RENAL

Kidney problems
Kidney stones
Prostate problems

RESPIRATORY

Emphysema
Lung disease
Sleep apnea
Tuberculosis

NEURO

Alzheimer's disease
Fibromyalgia
Parkinson's disease
Seizures
Stroke

ENT

Asthma
Cataracts
Glaucoma
Seasonal allergies

ENDOCRINE

Diabetes type: I or II
Thyroid disease

GI

Diverticulitis
Esophageal reflux
Gallbladder disease
Hiatal hernia

PSYCH

Alcoholism
Chemical dependency
Depression
Mental Health

HEMATOLOGY

Anemia
Protein C deficiency
Protein S deficiency

OTHER

Arthritis
Chronic back pain
Gout

PAST SURGICAL HISTORY:

Aortic surgery
Appendectomy
Back surgery
Carotid surgery
Colon surgery
Gallbladder surgery
Heart bypass
Heart catherizaton
Heart stent/balloon
Heart valve surgery
Hysterectomy
Leg bypass/stent
Pacemaker/AICD
Prostate surgery
Thyroidectomy
Tonsillectomy

HENDRICK CLINIC

MEDICAL HISTORY FORM
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NAME: _____DATE OF BIRTH: _____DATE:_____

REVIEW OF SYSTEMS: (Please circle the following which apply to your health.)

GENERAL

Chills
Fatigue
Fever
Insomnia
Loss of Appetite
Loss of weight
Night sweats
Weight gain

CARDIOVASCULAR

Chest pain
Fainting
Near fainting
Racing Heart beats
Sit up to breathe
Skipped beats
Slow Heart rate
Sweating-cold sweat
Waking up short of breath

ENT

Hearing problems
Hoarseness
Nasal Congestion
Nose bleeds
Sinus Congestion
Sore Throat

SKIN

Lesions
Rashes
Skin ulcers

GASTROINTESTINAL

Bleeding
Constipation
Diarrhea
Incontinence
Indigestion
Nausea
Reflux
Vomiting

GENITOURINARY

Bloody urine
Frequent urination at night
Painful urination
Urinary frequency
Urinary hesitation

NEUROLOGICAL

Any weakness
Dizziness
Headaches
Memory loss
Numbness
Seizures
Tremors

PSYCHIATRIC

Anxiety/Depression
Hallucinations

HEMATOLOGICAL/LYMPHATIC

Anemia
Bleeding problems
Easy bruising
Swollen glands

ENDOCRINE

Increased thirst
Increased urination
Intolerance of heat or cold

MUSCULOSKELETAL

Back pain
Pain in joints/muscles

RESPIRATORY

Cough
Coughing up blood
Shortness of breath
Snoring
Sputum production

EYES

Cataracts
Change in vision
Double vision
Glaucoma
Double vision

VASCULAR

Discoloration of legs
Pain in legs when walking
Swelling in feet or legs
Varicose veins

MALE REPRODUCTIVE

Erectile dysfunction

SLEEP DISORDER SCREENING:

Day time sleepiness
Difficulty concentrating
Difficulty sleeping
Gasping/Choking
Memory loss
Morning headaches
Restless legs
Sleep walking
Snoring
Uncontrollable urge to sleep
Unrefreshing sleep