| | | | | |
|---|---|---|---|---|
| Muncie | 2525 University Ave., Suite 300 | Muncie, IN 47303 | ph 765•281•2000 | fx 765•281•2040 |
| Muncie | 800 S. Tillotson Ave. | Muncie, IN 47304 | ph 765•281•2000 | fx 765•281•2044 |
| Cancer Center | 2401 University Ave. | Muncie, IN 47303 | ph 765•281•2000 | fx 765•281•2114 |
| Marion | 1399 N. Baldwin | Marion, IN 46952 | ph 765•651•2620 | fx 765•651•2630 |
| New Castle | 2200 Forest Ridge, Suite 120 | New Castle, IN 47362 | ph 765•593•2960 | fx 765•593•2965 |
| New Castle | 1000 North 16th, Suite 240A | New Castle, IN 47362 | ph 765•521•1461 | |


# Cardiology History Form

Name: ____________________________________________ Date: ____________________
Referring Physician: ______________________________________ Date of Birth: ______________

**Medical History:** Please check any of the conditions that represent a SIGNIFICANT problem for you

| General | YES | Cardiovascular | YES | Genitourinary | YES |
|---|---|---|---|---|---|
| Fever or chills | | Chest pain with activity | | Burning or painful urination | |
| Recent weight change | | Heart skips beats | | Frequent urination | |
| Fatigue | | Heart beats too fast | | Blood in urine | |
| Heat or cold intolerance | | Passing out spells | | Bladder infections | |
| **Head and Neck** | **YES** | High blood pressure | | Incontinence, dribbling | |
| Swelling in neck | | Heart murmur | | Kidney stones | |
| Prolonged hoarseness | | Bad heart valve | | Change in stream | |
| Sore throat | | Rheumatic Fever | | Irregular menses, female only | |
| Pain or stiffness in neck | | Feet or ankle swelling | | **Gastrointestinal** | **YES** |
| **Skin** | **YES** | Short of breath at rest | | Rectal bleeding | |
| Rash, dryness, itching | | Short of breath with exercise | | Blood in stool | |
| Change in nails or skin color | | Short of breath lying down | | Loss of appetite | |
| Bleeding, bruising tendencies | | **Lungs** | **YES** | Heartburn or indigestion | |
| **Eyes** | **YES** | Cough | | Chronic abdominal pain | |
| Glasses or contacts | | Cough with sputum or blood | | Chronic constipation | |
| Double, failing vision | | Wheezing | | Black or tarry stools | |
| Dry eyes | | **Musculoskeletal** | **YES** | Frequent diarrhea | |
| Pain or light sensitivity | | Swollen or red joints | | Difficulty swallowing | |
| **Ears, Nose, Mouth** | **YES** | Arm or leg weakness | | Nausea or vomiting | |
| Loss of smell | | Leg cramps | | Vomiting of blood | |
| Nose bleeds | | Difficulty in walking | | **Endocrine** | **YES** |
| Sinus problems | | **Neurologic** | **YES** | Night sweats | |
| Runny nose | | Light headed or dizziness | | Excessive thirst | |
| Postnasal drip | | Speech disturbances | | **Psychiatric** | **YES** |
| Earache or drainage | | Convulsions or seizures | | Depression | |
| Hearing loss | | Numbness or tingling | | Anxiety | |
| Ringing in ears | | Frequent headaches | | Nervous breakdown | |
| Dentures | | Memory loss | | Alcohol problems | |
| Sores in mouth | | Paralysis or weakness | | Physical, verbal, sexual abuse | |
| | | Sleep disorders | | Drug problems | |

**Past and Family Medical History:** Please check if you or your family have ever had any of the following

| | You | Family | | You | Family | | You | Family |
|---|---|---|---|---|---|---|---|---|
| Hypertension | | | Irritable Bowel | | | Rheumatoid Arthritis | | |
| Heart Disease | | | Jaundice | | | Thyroid Disease | | |
| Stomach Ulcers | | | Blood Clots | | | Rheumatic Fever | | |
| Seizure/Epilepsy | | | Depression | | | Liver Disease/Hepatitis | | |
| Diabetes | | | Tuberculosis | | | Breathing Problems | | |
| Cancer | | | Blood Disorders | | | Vision Problems | | |
| Renal Disease | | | Lupus | | | Hearing Problems | | |
| Ulcerative Colitis | | | Stroke | | | Glaucoma | | |
| Other | | | Other | | | Other | | |

Please list all of your medications, including over the counter medications (If you need additional space please bring a list, including dosages, to your appointment.)

| Name of Medication | Dosage | Number of Times Per Day | Reason for Medication |
|---|---|---|---|
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| | | | |

Please list all allergies including medications, food, and environmental

| Medication, Food, Other | Reaction |
|---|---|
| | |
| | |
| | |
| | |

Please list any recent hospitalizations, and surgeries, and an approximate date of hospitalization

| Date | Reason for hospitalization or surgery |
|---|---|
| | |
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| | |

**Social History:**

Marital Status: Single ❑ Divorced ❑ Married ❑ Widow/Widower ❑ Other ❑

Who lives at home with you? ________________________________________________________________

Who to contact in case of an emergency and phone number:_______________________________________

Current Occupation/Employer:____________________________________ Type of work: _____________________

Do you smoke? Yes ❑ No ❑ If yes, how many packs per day?_________________________________

Did you smoke? Yes ❑ No ❑ If yes, when did you quit? ____________________________________

Do you drink alcohol? Yes ❑ No ❑

If yes, indicate on average how much and check day, week, or month

_______Beer per: Day ❑ Week ❑ Month ❑

_______Glasses of wine per: Day ❑ Week ❑ Month ❑

_______Mixed drinks per: Day ❑ Week ❑ Month ❑

Patient Signature ______________________________________________ Date:______________________

Physician Initials ______________________________________________ Date:______________________