Mountain Medical

MEDICAL HISTORY QUESTIONNAIRE TODAY'S DATE: _____

*****Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All information is kept confidential. *****

NAME: _____ Male/Female AGE: _____ DOB: _____

Providers

Referring Provider: _____ Primary Care Provider_____
Cardiologist: _____ Any Other Provider assisting in your care: _____

Why are you here today?_____

Past and Present Medical Problems

High blood pressure Yes/ No Heart attack Yes/ No High cholesterol Yes/ No Stroke/TIA Yes/No

Heart Failure Yes/No Atrial Fib/Arrhythmia Yes/No PFO/ Hole in Heart Yes/No Cancer Yes/No

Coagulopathy/Clotting disorder Yes/No Diabetes Yes/ No Kidney disease Yes No Thyroid disease Yes/ No

Other Past Medical History not listed:_____
_____

Surgical History
Please list any surgeries that you have had in the past. Some of the more common ones are listed below
Please circle and date if relevant:
Amputation site_____ Date of surgery_____, Aneurysm repair/site_____ Date of surgery_____
Bladder/Prostate repair/ Date of surgery_____, Carotid surgery/ Date of surgery_____,
Cataract/ Date of surgery_____, Heart stent/bypass/ Date of surgery_____,
Laparoscopy (abdominal scope)/ Date of surgery_____, Lower extremity bypass/Date of surgery_____,
Pacemaker / Date of implant_____, Prostate repair/Date of surgery_____
Orthopedic surgeries (Knee, shoulder/rotator cuff, hip replacement) Date of surgery_____

Other surgeries or procedures _____
_____

Do you drink alcohol? ☐ Current everyday ☐ Current someday ☐ Former ☐ Never ☐ Unknown
Beer/Wine/Liquor How many per week? _____
Do you use recreational Drugs? ☐ Current everyday ☐ Current someday ☐ Former ☐ Never ☐ Unknown
Have you ever used tobacco? ☐ Current everyday ☐ Current someday ☐Former ☐ Never ☐ Unknown
How many packs per day **do you or did you** smoke? ☐ < ½ ☐ ½ ☐ 1 ☐ 1 ½ ☐ 2 ☐ 2 1/2 ☐ 3
How many years **did you or have you** smoked? _____When did you quit?_____

Family History- ***Please list which family member was affected***
Mother, Father, Brother, Sister, Grandmother (maternal/paternal)Grandfather (maternal/paternal)
Abdominal aortic aneurysm _____ Heart Disease_____
Bleeding Disorder _____ High Blood Pressure_____
Blood Clots_____ High Cholesterol_____
Cancer _____Type_____ Stroke_____
Diabetes _____

Current Medications and Allergies

Do you have any known Allergies to Medications? **Please Mark Box if None:** ☐

Iodine? ☐ Reaction _____ Latex? ☐ Reaction _____

Others? ☐ Please list Medication and Reaction

_____

_____

What is your current weight? _____ Height? _____

Please list all medications that you are currently taking (including insulin, over-the-counter medications, vitamins, diet supplements, herbal preparations, etc.).

Medication/Reason	**Dosage/Frequency**	**Medication/Reason**	**Dosage/Frequency**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

Plavix/Clopidogrel: Dose/Frequency _____ Reason_____

Coumadin/Warfarin: Dose/Frequency _____ Reason_____

Aspirin Dose/Frequency _____ Reason_____

Please list the Provider that is monitoring any of the above medications: _____

Review of Systems *Please circle if you have any of the following:*		
◊ **Constitutional**	◊ **Respiratory**	◊ **Neurological**
Fatigue/Drenching Night Sweats	Asthma/ Anesthetic problems	Migraines/Headache/Vertigo
Fever/Chills	COPD/Pneumonia/Emphysema	Temporary/Paralysis Arm/Leg/Face
General health excellent/Poor	Coughing/coughing up blood	Tingling/Numbness
Unexplained weight loss/Gain	Hoarsness/Obstructive Sleep Apnea	Speech difficulties/Seizures
◊ **Eyes**	Oxygen Dependent LPM _____	◊ **Musculoskeletal**
Blurry vision/Double vision	Shortness of Breath with Exertion	Artificial knee or hip joint
Cataracts/ Macular degeneration	Shortness of breath /Wheezing	Back pain/Joint pain
Glasses/Contacts/Blindness	Tuberculosis or exposure	Degenerative/Osteoarthritis
Glaucoma/Retinopathy	◊ **Gastrointestinal**	Muscle pain/Weakness/Cramps
Partial loss of vision/blind spots	Abdominal pain/Blood in stool	Rheumatoid Arthritis
◊ **Ears/Nose/Mouth/Throat**	Black or Tarry stool	◊ **Endocrine**
Dentures/Difficulty swallowing	Bloating/Diarrhea/Constipation	Cold/Heat intolerance
Hearing Loss/ringing in ears	Loss of appetite/Heartburn	History of drug resistant infection
Prolonged Nose bleeds	Nausea/Vomiting	
Voice change	Ulcer disease/Pain after eating	◊ **Psychiatric**
◊ **Cardiovascular**	Vomited blood	Anxiety/Depression
Ankle Swelling /Varicosities	◊ **Genitourinary**	Confusion/Memory loss
Calf pain with/without exercise	Impotence	Difficulty sleeping
Chest pain with exertion/Exercise	Incontinence /Difficulty Voiding	
Chest pain/ Heart murmur	Kidney stones	◊ **Heme/Lymphatic/Immune**
Dyspnea on exertion/Syncope	Suprapubic/Indwelling Catheter	Anemia/Low platelet count
Irregular/Rapid heart rate	Urgency/Blood in Urine	Bleeding disorder/Easy bleeding
Leg Pain/Cramping in legs at night	◊ **Integumentary (Skin)**	Easy bruising
	New skin lesions/Skin Cancer	Lymphoma/Leukemia
	Rash/Persistent itching	Frequent illnesses
Rv 6-27-12	Unhealed/Delayed healing of sores	