

Name _____ Date _____

PERSONAL HISTORY

Birthplace _____ Date of birth _____

Nationality _____ Religion _____

Marital status: Single Married Widowed Divorced Health of Spouse _____

Occupation _____

Residence past 5 years: _____

Education through _____ Sleep (unusual hours) _____ Aids to sleep _____

Recreation _____

Exercise _____

Any past use of: Alcohol _____ How much? _____ How long? _____

Tobacco (type) _____ How much? _____ How long? _____

Tea/Coffee _____

PERSONAL PAST HISTORY Have you ever had... (Check appropriate box below)?

| | Yes | No | | Yes | No | OPERATIONS: Yes | No | Year | ALLERGIES (are allergic to): |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|---|
| | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Yes No Year |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Tonsils | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Years on BP meds | _____ | _____ | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Appendix | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus antitoxin <input type="checkbox"/> <input type="checkbox"/> _____ |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Drug dependency | <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin <input type="checkbox"/> <input type="checkbox"/> _____ |
| High cholesterol/lipids | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Stomach | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa <input type="checkbox"/> <input type="checkbox"/> _____ |
| Years on ch/lip meds | _____ | _____ | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Breast | <input type="checkbox"/> | <input type="checkbox"/> | Iodine <input type="checkbox"/> <input type="checkbox"/> _____ |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever/sinusitis | <input type="checkbox"/> | <input type="checkbox"/> | Uterus / ovary | <input type="checkbox"/> | <input type="checkbox"/> | Other drugs <input type="checkbox"/> <input type="checkbox"/> _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | Prostate | <input type="checkbox"/> | <input type="checkbox"/> | List _____ |
| Need insulin to treat | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (yellow jaun.) | <input type="checkbox"/> | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Measles | <input type="checkbox"/> | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mumps | <input type="checkbox"/> | <input type="checkbox"/> | Hives | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Infectious mono | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Whooping cough | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Polio | <input type="checkbox"/> | <input type="checkbox"/> | Malaria | <input type="checkbox"/> | <input type="checkbox"/> | Angioplasty/stent | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | Meningitis | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac bypass | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diphtheria | <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> | Heart valve surg. | <input type="checkbox"/> | <input type="checkbox"/> | Foods <input type="checkbox"/> <input type="checkbox"/> _____ |
| Alcohol dependency | <input type="checkbox"/> | <input type="checkbox"/> | Pleurisy | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> | Shellfish <input type="checkbox"/> <input type="checkbox"/> _____ |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | INJURIES: Yes No Year | | | Cosmetics <input type="checkbox"/> <input type="checkbox"/> _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Head | <input type="checkbox"/> | <input type="checkbox"/> | Other <input type="checkbox"/> <input type="checkbox"/> _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Chest | <input type="checkbox"/> | <input type="checkbox"/> | VACCINATION: Yes No Year |
| Back trouble | <input type="checkbox"/> | <input type="checkbox"/> | Exposure to TB | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus <input type="checkbox"/> <input type="checkbox"/> _____ |
| Bladder infections | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones | <input type="checkbox"/> | <input type="checkbox"/> | Influenza <input type="checkbox"/> <input type="checkbox"/> _____ |
| Bleeding tendency | <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> | Back | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia <input type="checkbox"/> <input type="checkbox"/> _____ |
| Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> | Other <input type="checkbox"/> <input type="checkbox"/> _____ |



Park Ridge Cardiology

50 Hospital Drive, Suite 3-B
 Hendersonville, NC 28792
 Telephone (828) 684-2234

FAMILY HISTORY

Has any blood relative had any of the following? (Check appropriate box below, and if "yes", what relationship.)

| | Yes | No | Relationship |
|----------------------|--------------------------|--------------------------|--------------|
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Bleeding tendency | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Repeated infections | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chronic lung disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Severe allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mental illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Convulsions or fits | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Migraine headaches | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Obesity | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid trouble | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Peptic ulcer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chronic diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Alcohol dependency | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Drug dependency | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

| | Present Age or Age at Death | If living, health (good, fair, poor) If deceased, cause of death. |
|-------------------------|--------------------------------|--|
| Father | | |
| Mother | | |
| Brothers/Sisters | | |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Check here and use back if additional space is needed.

Children

| | | |
|----|--|--|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Check here and use back if additional space is needed.

HAVE YOU RECENTLY HAD

THE FOLLOWING: (Check appropriate box below)

| | Yes | No |
|--------------------------------------|--------------------------|--------------------------|
| GENERAL | | |
| Tire easily, weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Marked weight change | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitivity to heat | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitivity to cold | <input type="checkbox"/> | <input type="checkbox"/> |
| SKIN | | |
| Eruptions (rash) | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in color | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in nails | <input type="checkbox"/> | <input type="checkbox"/> |
| EYES | | |
| Trouble seeing | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Inflamed eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| Corrective Lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| EARS | | |
| Loss of hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| NOSE | | |
| Loss of smell | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent colds | <input type="checkbox"/> | <input type="checkbox"/> |
| Obstruction | <input type="checkbox"/> | <input type="checkbox"/> |
| Excess discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| MOUTH | | |
| Sore gums | <input type="checkbox"/> | <input type="checkbox"/> |
| Soreness of tongue | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental problems | <input type="checkbox"/> | <input type="checkbox"/> |
| THROAT | | |
| Postnasal drainage | <input type="checkbox"/> | <input type="checkbox"/> |
| Soreness | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| BREASTS | | |
| Lumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| CARDIO-RESPIRATORY SYSTEM | | |
| Cough, persisting | <input type="checkbox"/> | <input type="checkbox"/> |
| Sputum (phlegm) | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody sputum | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain or discomfort | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain on breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficult breathing while lying down | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| Vein trouble | <input type="checkbox"/> | <input type="checkbox"/> |

Name _____

Date _____



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Breakfast _____
 Lunch _____
 Dinner _____

DIGESTIVE SYSTEM Yes No

Change in appetite

Difficulty swallowing

Heartburn

Abdominal distress

Belching or excess gas

Abdominal enlargement

Nausea

Vomiting

Vomiting of blood

Rectal bleeding

Tarry stools

Dark urine

Jaundice

Constipation

Diarrhea

Hemorrhoids

Need for laxatives

GENITO-URINARY SYSTEM

Increase in frequency of urination (day)

Increase in frequency of urination (night)

Feel need to urinate without much urine

Unable to hold urine

Pain or burning with urination

Blood in urine

Kidney disease

Impotence

Lack of sex drive

Pain with intercourse

ENDOCRINE Yes No

Thyroid trouble

Adrenal trouble

Cortisone treatment

Diabetes

LOCOMOTOR

Muscle cramps

Muscle weakness

Pain in joints

Swollen joints

Stiffness

Deformity of joints

NERVOUS SYSTEM

Headaches

Dizziness

Fainting

Convulsions or fits

Nervousness

Sleeplessness

Depression

Change in sensation

Memory loss

Poor coordination

Weakness or paralysis

OB-GYN

Started menstruating at age ____ Date of last PAP test _____

Interval between periods _____ Duration _____ days

Flow: light normal heavy Date last period _____

Pain with periods: yes no Duration _____

Number of pregnancies _____ Number of miscarriages ____

Number of births _____ Weight of babies at birth _____

| Medicines taken regularly | Reason | Last Dose |
|---------------------------|--------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Physicians Notes: _____

Name _____ Date _____

Physician's Signature _____ Date _____